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ABSTRACT

This guide is designed for individuals working in community mental health centers or other mental health programs concerned with needs and problems of the elderly. Section One examines the mental health needs of the elderly, and identifies major community social support programs that help the elderly with social and economic needs. Section Two presents a conceptual model of community mental health services. Section Three discusses major principles useful in developing community mental health programs for the elderly and describes the program organization and evolution of seven such programs. Section Four provides information about federally supported programs relevant to the aged. The fifth section describes the purposes of different mental health program components. The appendices contain selected references and directories of agencies and institutions to which references are made in Section Four. (Author/NRB)

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A RESOURCE GUIDE FOR MENTAL HEALTH AND SUPPORT SERVICES FOR THE ELDERLY

Ruth Knee and Gladys Krueger
For the
National Institute of Mental Health

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Center for Studies of the Mental Health
of the Aging
National Institute of Mental Health

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(In this text, unless direct reference is being made to a particular individual, the use of the masculine gender also includes the feminine gender.)

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FOREWORD

The prevalence of mental illness among the elderly residing in communities and in institutions has been well documented (15 to 25 percent in communities and 50 to 75 percent in institutions). In contrast to this high prevalence rate is the relatively low rate of utilization of community mental health services by the elderly; only 4 percent of those served are over age 65. Foremost among the numerous explanations for this low utilization rate is the lack of specialized geriatric mental health services available, accessible, and acceptable to the elderly.

In the past 7 years, there has been dramatic increase in the amount of information available to mental health professionals about the range of possible approaches to the delivery of geriatric mental health services. On a national level, for example, the Secretary's Committee on the Mental Health and Illness of the Elderly and the President's Commission on Mental Health provided recommendations on the design of geriatric mental health service systems. In addition, the enactment of Public Law 94–63 in 1975 required community mental health centers (CMHCs) to provide specialized services for the elderly.

While there has been a great deal of activity at all levels of government and many significant program efforts have been initiated, mental health dollars for either the development and/or the support of specialized geriatric services are extremely scarce. Moreover, there is a need for comprehensive health, mental health, and social service development to address the complex situations in which many older persons find themselves.

Since 1975, program staff of CMHCs have found it increasingly difficult to identify and obtain mental health funds for either the development or support of comprehensive geriatric mental health services. Recognizing that mental health dollars alone were not sufficient for the task of developing comprehensive geriatric services, program staff began to search outside mental health. They soon realized that the world of multiprogram support was complicated and filled with numerous rules and regulations—sometimes complementary, usually not. In this multiprogram support, only the most hardy and skillful were able to manage.

The purpose of this *Resource Guide* is to bridge the gap between the geriatric mental health service program and those programs offering support of complementary social and health services to the elderly. It provides a context for developing a range of approaches to comprehensive geriatric mental health services.

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Along with the enactment of the Mental Health Systems Act (PL 96–398), the *Resource Guide* will help to establish a framework in which mental health services can be planned and delivered. The trend suggested by the Mental Health Systems Act is toward systems development, with a strong emphasis on coordination with health and other related services. The *Resource Guide* should prove to be valuable in planning geriatric mental health services within an overall systems approach.

Finally, the users of the *Resource Guide* are reminded that its goal is to offer alternative approaches to the development of comprehensive programs for elderly individuals in need of mental health services. It is hoped that it will assist in increasing the quantity and quality of mental health services to the elderly.

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PREFACE

The past few years have witnessed intensive national reviews of the state of mental health related services for the elderly. The President's Commission on Mental Health, The Secretary's Committee on Mental Health and Illness of the Elderly, and The National Conference on Mental Health and Aging, coordinated by the U.S. House of Representatives Select Committee on Aging, all strongly emphasized the need for improved responsiveness of community service programs to the mental health programs of older Americans. And the work around the 1981 White House Conference on Aging continues to voice this nationwide concern. Meanwhile, The Mental Health Systems Act of 1980 mandates new responsibilities and sets the stage for new opportunities in providing a range of services for older people. With all of this activity service providers have become aware of their potential role and the unique contributions they can make in working with older persons in need of mental health assistance. At the same time, there has been increasing understanding by the elderly and their families of different mental problems that can respond to treatment—and they are seeking help.

Obviously critical to the ability of older people to have access to mental health related services and to the capacity of service providers to deliver them are the resources available to meet costs, expenses, and other needs. Toward the goal of improving the ability of service programs addressing the mental health needs of the elderly to take better advantage of available resources, this *Guide* strives to delineate existing resources from the perspective of reimbursement to the service program and benefits to the older individual. Moreover, these resources are looked at within the context of a conceptual model of community mental health programs for the elderly that takes into consideration principles of care and creative mixing of available resources for improved organization and delivery of services. Ruth Knee and Gladys Krueger, who developed this *Guide*, have made a major contribution both to the field of mental health and aging and to the public with the important information included in this volume.

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I. INTRODUCTION

The goal of a program of community mental health services for the elderly is to develop a comprehensive range of services—from prevention through treatment and rehabilitation.

The community mental health center (CMHC) has a unique responsibility for carrying out mental health services for the elderly. The Community Mental Health Centers Act of 1975, Public Law 94-63, Section 201(b)(1) specifically required: "A program of specialized services for the mental health of the elderly including a full range of diagnostic, treatment, liaison and follow-up services (as prescribed by the Secretary)."

The CMHC provides some services directly. When it does not have direct control, it must know how to draw on or help develop the other community resources that are essential to promote the well-being of the elderly.

Communities that do not have a CMHC can also use the ideas and resources presented in this guide in meeting the mental health needs of their aged. This presupposes the existence of a community agency that has the interest and capability to take responsibility for developing and sustaining a mental health program.

The CMHC has three major concerns with mental health services for the elderly:

- To see that all social and health services in the community for the elderly have an appropriate mental health content
- To assure that the mental health needs of the persons receiving these services are appropriately identified and met
- To assure that the mentally ill who are seen in the mental health services system receive the range of social and health services which they need.

The individual center must decide on the allocation of its resources and efforts among these concerns, depending on its perception of community needs and its own capabilities.

This guide is addressed to those of you working in CMHCs or other mental health programs who are concerned with the needs and problems of the elderly. It attempts to provide information that can help you:

- Identify different kinds of mental health services that are needed by the elderly and that can be provided to them by CMHCs.

- Creatively use the many different kinds of resources available to support these services.
- Identify major community social support programs that help maintain the functional capacities of the elderly and help them with social and economic needs which affect their mental health.

In section II, the guide presents a conceptual model of community mental health services. This model reflects the approach and philosophy of the Center for Studies of the Mental Health of the Aging, National Institute of Mental Health (NIMH). The Institute has major responsibility for the mandate that CMHCs provide mental health services to the elderly.

Section III sets forth major principles that have proven useful in developing community mental health programs for the elderly. In this section, the program organization and evolution of seven different community mental health programs for the elderly are described.

Section IV includes information about major federally supported programs that are relevant to the aged and available for use by community mental health staff.

In section V, the purposes of different mental health program components are described. Examples are provided in terms of program goals and the resources available to help meet these goals.

In 1977/1978, directors of the seven community mental health programs included in section III provided information about the development of their programs for the elderly, in response to a request by Dr. Gene Cohen, Chief, Center for Studies of the Mental Health of the Aging, NIMH. The following agencies and their staffs contributed:

Southeast Community Mental Health Center
4190 Mission St.
San Francisco, Calif. 94112

Sunset Community Mental Health Center
(District V)
2145 19th Ave.
San Francisco, Calif. 94116

Prairie View Mental Health Center
East First St. - P.O. Box 467
Newton, Kans. 67114

Massachusetts Mental Health Center
74 Fenwood Rd.
Boston, Mass. 02115

Center for the Study of Aging and Human Development
Duke University Medical Center
P.O. Box 3003
Durham, N.C. 27710

West Philadelphia Community Mental Health Consortium, Inc.
P.O. Box 8076
Philadelphia, Pa. 19101

Weber-Morgan County Comprehensive Mental Health
350 Healy St.
Ogden, Utah 84401

Section IV is organized so that it can be used as a reference for questions about a particular resource or where to go for more information. For the more important federally sponsored programs, it sets forth the provisions that are uniform on a nationwide basis and major State-to-State variations. It cannot supply information on all State and local variations. For example, for the Medicaid program, eligibility requirements, services coverage, and reimbursement rates are different from State to State and may vary within a State. As a user of the guide, you are encouraged to record for future reference the particular variations of any program that are applicable to your community and State. The information in section IV reflects program provisions as of July 1, 1979. It is important to keep in mind that Federal programs change as a result of changes in legislation and funding.

Information for the major federally supported programs included in section IV was drawn from a variety of sources: (1) the Federal laws; (2) *Catalog of Federal Domestic Assistance;* (3) *Funding in Aging—Public, Private and Voluntary, 1979 Edition;* (4) *Social Security Handbook*; (5) brochures, pamphlets, information sheets, and other publications issued by the various Federal programs; (6) Third-party reimbursement seminars sponsored by the National Institute of Mental Health and presented by A.L. Nellum and Associates and

Macro Systems, 1976. For the reader who wants to pursue more sources of support for the aged, appendix A provides a description of items (2) and (3) and information on how to obtain them. Appendix A describes several additional references which the reader may find useful.

Appendixes B through G consist of directories of agencies and institutions to which reference is made in section IV:

B. Selected DHHS Regional Office Staff
C. State Mental Health Authorities
D. State Agencies on Aging
E. Medicaid Directory
F. State Title XX Agencies
G. VA Installations—Where To Go for Help

II. CONCEPTUAL MODEL OF COMMUNITY MENTAL HEALTH SERVICES FOR THE ELDERLY

A. Interface of Mental Health Services With Other Services for the Elderly

A mental health program for the elderly has to be put together at the community level and must be linked to the total network of health services and community and social support services available to the elderly. The mental health program is one integral component of a total program of comprehensive services for the elderly.

Elderly individuals in need of help must be approached as "total persons." Their mental problems cannot be separated from their physical problems or from the social and economic situation in which they find themselves.

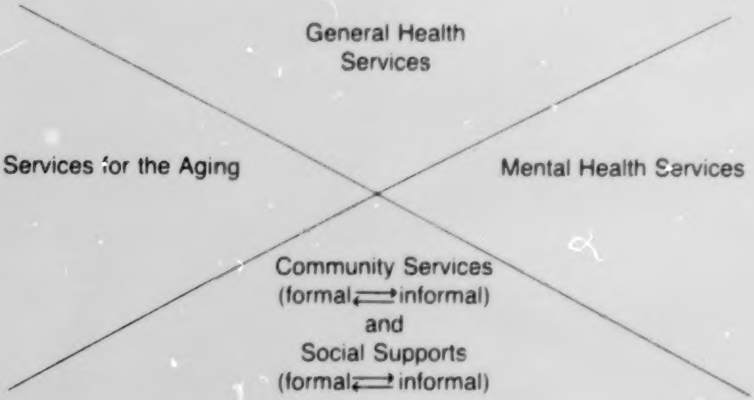
No single agency can possibly assume total responsibility for all of the services needed by the elderly or deliver them under one roof. No single agency has the resources, authority, personnel, or skills to do it. The role of the mental health agency is:

1. To identify the mental health needs and to locate the resources in each major geographic area that develops a comprehensive mental health services plan for the elderly

2. To provide the linkage between individuals in need of special services and resources that help meet the need

3. To work with the community in planning and coordination roles to make local resources responsive to the mental health needs of the elderly

The mental health agency staff dealing with the elderly must consider how the mental health programs fit into the network of total services available to the elderly. Four major components of this network are shown in the following schematic diagram. These four components are used in the subsequent description of potential resources that can be brought to bear on the mental health needs of the aging.


General Health Services
Services for the Aging
Mental Health Services
Community Services (formal ⇄ informal) and Social Supports (formal ⇄ informal)

B. Definition of the Elderly

An arbitrary age definition is often used for purpose of eligibility for specified services. Some major resources for the elderly define eligibility in terms of age 65 years or older, for example, Medicare and Supplemental Security Income. Some programs specify age 62, age 60, or age 55; others have no age specification. Community mental health centers should include in their services programs for the elderly people who are younger than age 65. It is known that the proportion of people with mental health problems increases with age. Therefore, a CMHC involved in preventive activities might well want to include younger persons.

Programs for the older disabled and chronically mentally ill have to be geared to the functional levels of persons as well as to age vulnerability. The services in a mental health center, for example, the clinical programs, should be available to persons of all ages with no automatic age cutoff. To take the position that persons over a certain age cannot benefit from psychiatric treatment is untenable.

C. The Role of Psychiatric Treatment and Other Medical Treatment for the Elderly Patient

Psychiatric treatment should have a modest objective for most elderly patients—to help them adjust and function in day-to-day living, rather than to undergo deep therapy to accomplish personal realignment.

Physical problems, along with mental problems, are increasingly prevalent at various functional levels of the older patient. Therefore, the mental health center must have a medical evaluation of the patient. This will frequently require referral of the patient to a physician, and establishing relations with those physicians and clinics that will be involved in any necessary follow-up. Adequate attention to his physical problems can help the older person function in the face of mental problems.

D. Some Special Considerations

One of the major characteristics of older people who have functioned well is that they do not seek out help with their mental problems. Therefore, support services need to be offered in the places where they live, for example, senior citizens buildings, or places where they ordinarily go.

Many of the elderly are less able than younger persons to make their way through the complex maze of resources available to them. There must be an active outreach program for these individuals.

Much is done for the elderly person through support services, for example, transportation, telephone assurance, meals on wheels. Mental health center staff must know about all possible support services, how to use them, and how to develop them if they do not exist.

E. Strategies for Use of Multiple Sources of Support

Multiple sources of Federal, State, local, and private program entities and funds make up the community network of services for the elderly. The CMHC has limited control over most of these resources but has to make use of all of them. Some strategies that mental health centers have used effectively include:

1. *Formal interagency working agreements* concerning such program aspects as information exchange, referrals, reimbursement, consultation arrangements, staff interchanges.
2. *Exchanges of services* (without extra reimbursement); for example, a senior center might offer recreational activities for the CMHC's elderly patients, and the center staff might provide program consultation and case consultation to the senior center.
3. *Co-location of staff* in order to allow easier access to mental health staff. A senior center might provide office space for CMHC staff, or the center might provide the facilities for a health screening or a home health unit.
4. *Community-based planning groups or coalitions* organized to cut across program boundaries and involve both providers and consumers interested in mental health services and the elderly.
5. *Informal neighborhood networks* as the nucleus of both preventive and support programs.

The CMHC should use mental health funds for specific or specialized mental health services. This can be done through interagency agreements and pooled funds as well as through direct expenditures. The CMHC should find ways to have basic health and social services paid from other resources. Third-party reimbursement payments for health care services should support the major part of direct treatment. Program funds for human services should provide for the entire range of social support services and educational activities.

F. Incremental Development of Mental Health Services for the Elderly

Community mental health services for the elderly should be developed in balance with community resources for meeting other kinds of needs of the elderly. Assessing the needs of elderly persons in the community and assessing the resources that are available to meet those needs are initial steps in developing a mental health program for the elderly. The efforts required to develop comprehensive services for the elderly depend on what already exists in the community. For the services that need to be developed, it is necessary to determine whether it is appropriate for a particular service to be located in a CMHC or whether it might better be sponsored by another community agency. Most programs must be developed incrementally, based on long-range plans, but with a great deal of flexibility regarding priorities and short-range goals.

III. PRINCIPLES AND PATTERNS OF DEVELOPMENT OF MENTAL HEALTH SERVICES FOR THE ELDERLY

Building a mental health service network for the elderly takes time. Long-range planning, an incremental approach, interagency coordination, and use of multiple sources of funding and other resources are all essential components of successful program development. Each center or community mental health program needs to find its own approach, since needs, priorities, and resource availability vary from one locale to another.

A. Principles

Some principles which have been used in program development by established geriatric mental health programs are:

- Plan on an incremental approach. Start with a single service or with serving only a part of a catchment area, particularly if it is an area that covers several counties or political jurisdictions.
- Start with services on a pilot or demonstration basis. Be sure to specify a time period for this initial phase with some agreed-upon and simple criteria for evaluating whether the service or program should be continued as is, modified, or discontinued.
- Don't duplicate existing services or programs. If some population groups are not being served because of noneligibility or geographical limitations, see if the existing program can be expanded.
- Identify gaps in existing programs and/or in the linkages between mental health and other health and human services programs. See how the mental health program can fill these gaps with least staff.

- Obtain assistance from community groups and other programs in identifying gaps and needs, but retain decisionmaking and direction within the mental health program.
- Learn to use multiple resources, money, and services in-kind. It may take a combination of several funding sources to support a single program element, such as daycare.
- Develop trade-offs with other programs—money, staff, services. Working agreements should be a two-way street.
- Be cautious about putting too much emphasis on a single service just because the money is available; this may lead to its inappropriate use.
- Know the territory in terms of its demographic characteristics, community patterns, mental health, physical health, and social services delivery systems on the one hand; and political clout and connections of categorically interested groups concerned with the elderly, especially consumer groups, on the other.
- Don't oversell in order to obtain special money. Don't promise something that cannot be delivered.
- Don't place too much dependence on a single Federal program. Most programs make changes in direction and have time limits.
- Develop an information file on all the public programs that have relevance to your program plans and directions—Federal, State, county, city, region, parish, conservation district.
- Get acquainted with the directors or managers of other programs. Health and welfare councils, senior citizens councils, and community planning groups may be good vehicles for getting acquainted.
- Explore how to get maximum support from levels of organization closest to the program you are planning. Examples are State agency to State agency; and CMHC to local bodies, such as county board of supervisors, area agency on aging, local United Way.
- Learn the language and priorities of other programs and funding sources. For example, pre-retirement mental health group counseling can be considered as adult education as well as a preventive mental health service.
- Be accountable for funds and responsibilities which you have accepted. Don't accept funds or responsibilities for which you cannot be accountable.
- Learn to determine cost of activities and program elements, even if you don't have to report this to a third-party payer. Some indirect services can be relatively costly.

- Keep records of community activities as well as clinical services.
- Explore new ideas with other groups serving the elderly.
- Know the limitations of third-party and other payment programs. Don't try to stretch them to cover noncovered services. But do work with others to try to remove discriminations and achieve adequate coverage.
- Develop interagency agreements which will improve the CMHC's program of mental health services for the elderly by making them more comprehensive or by getting an individual into service earlier, even if these agreements do not add to the revenue of the CMHC.

B. Patterns of Program Organization and Evolution

One of the most important roles of the geriatric mental health service within a community mental health program is to serve as a *catalyst* or *broker* in order to develop linkages between elderly individuals in need of mental health services and the resources that can meet their needs. This involves sensitizing many "generic" agencies or programs to the needs of the elderly and or the mentally ill and helping these agencies do their job in serving the mentally ill elderly. It also means educating the community, including the elderly, on how and where help with mental health problems is available. These efforts must extend to the taxpayers, officials, and legislators responsible for local and county government and to third-party payment programs, if adequate financial support is to be received for mental health services.

The following examples illustrate different philosophies of geriatric mental health service programs and different patterns of program development, organization, and funding. Each of the geriatric community mental health programs described is a component of a larger mental health program or human service organization. None of them is free-standing. Each of them shares some "generic" components with the larger agency in which it is located, and each has developed some kind of specialized service. There are numerous variations in staffing patterns and funding arrangements.

Model A—Inner-City CMHC as Part of a Consortium

Located in an Eastern inner-city area, this program is a component of a consortium which is one of the largest CMHCs in the United States. The consortium is composed of the following units: Five counseling centers, an inpatient unit, an emergency service, two aftercare centers, drug and alcohol services, mental retardation services, consultation and education, a center for women in transition, and an extensive older adult service. Nearly 600 employees deliver the services of the mental health consortium. There is a board of directors with half of the board members elected community representatives and half representatives of the institutions that make up the consortium.

The Older Adult Project was initiated at a time when the University School of Medicine, Department of Community Medicine, was developing a Gerontology Project and had a small budgetary surplus. With State approval, a small grant from those funds was approved for a 10-week pilot project. The main objectives of this Older Adult Project were to:

1. Provide outreach, support, information, referral, and direct casework assistance to the elderly in areas of medical, financial, mental health, recreation, and home-help services
2. Train selected older local residents to use their talents and interests in working with the elderly
3. Provide a visible symbol of concern for the aged
4. Act as an advocacy link between resources and older people
5. Document need and stimulate the creation of new and preventive services

Initial community interest and involvement in the mental health activities for older adults grew out of the outreach activities of one counseling center in the consortium. The center began working with an organization which had been established by a group of Protestant clergymen who had become concerned about the elderly in their congregations. Stimulated by the potential of a joint undertaking, the consortium collaborated in planning the initial demonstration project. It was anticipated that an active outreach program of this kind would help to identify and alleviate some of the problems of the elderly and enhance some aspects of their day-to-day living. Between 1970 and 1977, this Older Adult Project grew to include a staff of about 65 persons, 60 percent of whom are over the age of 60, and a volunteer service of 150 older volunteers.

The consortium has been designated by the Area Agency on Aging to deliver services to the elderly. Currently, the consortium operates three multipurpose senior centers and two satellite centers for persons 60 years and older. Services include: nutritional services, transportation, social services, socialization and recreation activities, health services, information and referral, outreach activities, volunteer services, a food cooperative, telephone reassurance, and chore services. These services are funded by the Metropolitan Corporation for Aging, which provides 75 percent of the budget; the County Office of Mental Health/Mental Retardation; and Title XX. The consortium has also established a geriatrics day hospital. This was initiated with the help of a foundation grant and is being sustained by Medicaid reimbursement.

In-home services and domiciliary care are administered by the local Area Agency on Aging but are considered an integral part of the mental health service system. The Older Adult Service administrative office houses the in-home service coordinators and a secretary. The Domiciliary Care program is linked by staff referral and followup from the Older Adult Service.

In 1977, a Geriatric Mobile Mental Health Unit was added as a result of the Federal Conversion grant. Four staff members—a unit director, social workers, nurse, and mental health assistant—have been hired to (a) handle assessments and direct mental health intervention in counseling centers; (b) go into nursing homes, hospitals, and boarding homes to do emergency intervention and followup; and (c) handle mental health problems of the elderly on an emergency basis. The unit is designed to educate, assess, and provide direct mental health services to the elderly population.

A grant was obtained from CETA (Comprehensive Employment and Training Act) to handle three functions: (a) a transportation coordinator and secretary, (b) three pre-retirement educators, and (c) two alcoholism outreach workers. This program will allow the consortium to develop an integrated transportation service to make maximum use of their eight vans and one bus.

Model B—Clinic Specializing in Geriatric Mental Health

This clinic, specializing in geriatric mental health, is operated by a University Center for the Study of Aging and is one of the hospital clinics of a southern university medical center. It serves as an affiliate of the county community mental health center for the delivery of mental health services to the elderly in the catchment area, which is a combination of urban, suburban, and rural areas. It also maintains a "special connection" with the Area Agency on Aging through a technical assistance program; i.e., clinic personnel serve as instructors in the training program developed by the aging network.

The county community mental health center is directly responsible to the county commissioners. Within the county CMHC, there is a coordinator of adult services who is responsible to the medical director of the CMHC. Among the special duties of this individual is the responsibility for services to the elderly. The county CMHC has developed an aftercare program for patients discharged from the State hospital. This program occasionally serves elderly clients and there is a nurse in charge of the program responsible to the coordinator of adult services within the county CMHC. While the clinic serves as a satellite of the county CMHC, the county CMHC has no administrative responsibilities for it. Most elderly people who contact the county CMHC are referred directly to the clinic without actual personal contact with the county CMHC. Each of the clinic staff members is especially concerned with the delivery of geriatric services.

The clinic was initially an outgrowth of the Information and Counseling Service of the University Center for the Study of Aging, and it developed as an incidental part of a program of policy research on alternatives to institutionalization for impaired older persons. A major task of this research—the construction of reliable, valid procedures for multidimensional assessment of individual functioning—required clients in a clinical setting. The assessment instrument which emerged proved to be useful both for clinic intake, management planning, and followup, and for surveys that identified untreated impairments of individuals within the community. Coincidentally, the State legislature created a Mental Health Commission in 1974 to review existing services and recommend new initiatives. One of the recommended initiatives was the creation of model mental health screening and treatment facilities for older persons. Within a year, the extension of the Federal Community Mental Health Act was to mandate services for elderly persons, and Title XX of the Social Security Act provided a new source of funds of potential significance for mental health. The State Division of Mental Health Services was interested in a model mental health screening and treatment facility for older persons. The county CMHC was interested in responding to the new Federal mandate, particularly if the new service could be financed in part from Title

XX funds which required only a 25 percent match. Title XX funds became available to the county CMHC which then subcontracted for services to the elderly with the clinic. This procedure worked well until Title XX funds were not available for this particular service within the county. At that point, the clinic began negotiations with the hospital of the University Medical Center and became an affiliate clinic within the hospital clinics. At the same time, the clinic continues to maintain a satellite and affiliate relationship with the county CMHC.

Being in a university medical school setting, clinic staff are medically oriented and include two part-time psychiatrists, a medical director who is an internist (10 percent time), a nurse (20 percent time), a full-time social worker, an interviewer, a record librarian, and a secretary. The clinic also has a training function with trainees from many different university departments and visiting scholars or specialists.

Clinic goals include evaluation research, training, and service delivery. The clinic serves as a model evaluation and treatment facility for the elderly. Services include mental health assessment, psychotherapy, psychotropic drugs, medical services, nursing services, relocation and placement services, administrative, legal, and protective services, and a coordination of service delivery. The goal is to attend to the full range of needs of the impaired elderly within the community, with the realization that there is a high probability that older persons with multiple impairments have mental health impairment. Most supportive services have to be obtained from community agencies. Each community agency has appointed a liaison person to the clinic, and regular meetings are held with that person.

Model C—Rural "Free-Standing" CMHC

This is a long-established "free-standing" community mental health center located in a rural area of a midwestern State. It is one of several private, nonprofit mental health centers sponsored by a church-related mental health service. The center is governed by an 18-member board of directors which represents the community at large and the sponsoring churches. In addition to the governing board, each county in the catchment area, which includes three counties, has an advisory committee composed of seven persons. This advisory committee gives counsel to the center and the county commissioners concerning both fiscal and program issues. The center is organized on the basis of three service-delivery divisions: Community Services, Hospital and Clinic, and Growth Associates. The center, especially through the Hospital and Clinic Division, serves private patients from a wide geographic area. The primary responsibility of the Community Services Division is to serve the tri-county Community Mental Health Catchment area. A Department for Services to the Aging has been established within the Community Services Division.

The center has satellite offices in the two outlying counties. They are at different stages of development. One has been able to establish an active relationship with the Area Agency on Aging.

Because the center provides few ancillary services as such, most social support services have to come from community agencies.

Historically, center staff have had an interest in aging which predates the specialized program. In the 1960s, an Aftercare Project, funded by NIMH, provided the center with an opportunity to develop untraditional patterns for meeting mental health needs of individuals in the community. This took the center staff into the community to view mental health needs from a different perspective and to provide the services of a visiting nurse. Because some of the aftercare patients were placed in care homes in the community, staff found themselves involved in a number of nursing homes and personal care homes for the aging psychiatric patient. The center has contracts with the three counties to furnish continuing mental health services and, thus, has provided for the extension of this aftercare service beyond the Federal grant period. In its commitment to meet the total mental health needs of the three county areas, the center has seen the needs of the aging person as a high priority area. There is a high concentration of homes for the aging in these three counties.

The aim of the ongoing program for the aging is fourfold: first, to adequately meet the psychiatric needs of the aged person in the catchment area which involves improving psychiatric diagnosis and clinical treatment, attempting to restore each individual to his highest level of functioning, and improving the care provided in the nursing homes and homes for the aging in the area; second, to provide knowledge about the process of aging to the community at large and particularly to persons working with the elderly in care homes; third, to develop more resources for the elderly, including the promotion of County Councils on Aging; and fourth, with the concept of prevention, to work with industries and a variety of community groups to try to shape some of the policies that have contributed to society's attitude toward the aging. This attitude has to do with mandatory retirement, inadequate retirement planning, inadequate housing, inadequate transportation, inadequate nutrition for aging persons. By influencing social policies in a number of areas, the program hopes to provide a better life for the aging citizen and prevent the isolation and physical deterioration that results from inadequately met needs.

The center finances most of its services on a fee-for-service basis. Fees are based on the customary charges per unit of service, i.e., inpatient day, partial day, hours of individual therapy. Medicare, Medicaid, and private health insurance reimbursement are received. In addition, State and county funds, under contract, are used for mental health services in the tri-county area. The goal of the Department on Aging is to operate at a slight margin of income over expenses and overhead. During the time that the department is in its developmental stages, some of the money which comes to the center from the State will be used as a subsidy to the department. A serious problem is the lack of third-party payments or other available funds to pay for the nursing home consultation and other educational activities. The center policy is to assess fees for workshops and seminars, and to limit outreach activities to persons who see the value in paying for them, such as nursing home staff.

Model D—CMHC as a Unit of County Government

This center, located in a Western mountain region, is a mental health center which is an element of county government, answerable to the county commissioners who are, by State law, the local mental health authority. The statute makes provision for a Citizens Advisory Council, appointed by the county commission, which functions as a 12-member policy board for the center. Some of these members are assigned to various program aspects, and they provide liaison to other county human services agency boards. Reciprocally, the mental health board has liaison members from those other agency boards, including the County Agency on Aging. Additionally, the mental health board has a number of advisory committees, one of which is composed of nursing home residents.

The mental health program for the elderly is actually an amalgam of the mental health center, the Department on Aging, and other support services from the human services system in the county. Since the center was opened in 1970, community services for the aging population have been a top priority. The center does not identify a specific geriatric team, but, rather, it provides services in nursing homes through its Intermediate Services Team and its Nursing Team and coordinates with the Department on Aging regarding general geriatric problems in the county. Other services may be given to elderly clients by the Acute Services Team and or one of the center's psychiatrists. A Consultation and Education Team is being developed which may take over some of the nursing home liaison activities.

Both the Mental Health Center and the Department on Aging are components of the Human Services System, whose director is responsible directly to county commissioners. Each has independent boards or councils that act in behalf of, and assist in, the development of policy and staffing guides and program implementation for the two agencies. Each department has a director to whom the service personnel are responsible. While staff are not interchangeable, each agency does use staff from the other departments in an advisory capacity, on a consultation basis, and in cooperative ventures such as joint staffing to establish the case management responsibility, and joint followup and evaluation.

The center program for the elderly is based on some assumptions which have an influence on both the organizational structure and the approach to service delivery:

1. The older person in the community has a negative view of mental health treatment.
2. Most treatment can be accomplished by using existing resources without labeling the older person as a mental health patient.
3. Most treatment plans for the older person are in reality a manipulation of the person's behavior and or environment.
4. Expectations or goals must be individually developed so that they are flexible enough to meet the uniqueness of each individual's needs, based on the physical and mental ability of the person receiving the service.
5. If people are not labeled mentally ill and segregated, they are more acceptable in community groups.

These goals and assumptions promote mental health treatment in settings which are more accessible to the patient and which allow for a more normal lifestyle for the geriatric patient. Hospital or nursing home care is used when needed for the individual but not as a substitute for community agency services. The assumptions and goals also provide the basis for an affiliation agreement between the Council on Aging and the mental health center which defines the mutual supports provided and the differential roles of each agency. Individuals may initiate their request for help through either agency.

The integration of these two programs is furthered by the area agency on aging and the mental health center director being housed in the same building and sharing the same switchboard. The center director chairs the finance committee of the Council on Aging and sits on the Council's Executive Committee. The director of the Department on Aging sits on the advisory boards of the mental health program. The aging program operates five senior citizens centers nutrition sites which provide support services and which do much of the intake for the mental health program. The mental health center helped to initiate these senior citizens centers through providing organizational support services and financial support.

Funding for these various services comes from a mix of State county appropriated funds, Title XX (earmarked by State legislation), Older Americans Act (Titles III and VII), and Medicaid. The Human Services System within the county and the State allows flexibility in combining funds from various State, county, and Federal programs.

Model E—Geriatric Service Unit of an Urban Council of Churches

This Geriatric Service Unit is a major component of a highly organized Council of Churches located in a west coast metropolitan area. The Council, because of its long-time involvement with the elderly and its interest in mental health issues, contracted to provide geriatric services in one of the five mental health catchment areas of the city. The particular catchment area has a high proportion of single, middle-class, poor elderly, and minority populations living on fixed incomes. Two-thirds of the residential care homes for the ambulatory aged within the city are located within this catchment area. The Council also administers several programs funded by the Area Agency on Aging.

The specific aim of the Geriatric Service Unit is to enable senior clients to stay in their own community as long as possible and, if hospitalized, to avoid long-term hospitalization. To that end, it is the Unit's goal to act as an advocate for senior citizens and either mobilize existing services or provide services not otherwise available.

When the CMHC catchment area was formed, a series of public meetings was held to let the community know that mental health services were going to be made available. Task forces composed of community members developed a service plan and a preliminary budget which was astronomical. The task force chairman, meeting as a Citizens Advisory Committee, worked out a more realistic budget and established priorities for the area. Since geriatrics was one of the high priorities, a small program was initiated. When the NIMH staffing grant became available, the geriatric service program was enlarged considerably. The geriatric service program uses funds from many sources, including NIMH grants, State-local mental health matching funds, city tax funds, community college funds, area agency on aging funds, and ACTION.

The district CMHC, which is the contracting agent for the geriatric service, has a citizens advisory board consisting of 24 residents of the area who represent the various age, ethnic, and socioeconomic groups. Inpatient, 24-hour emergency, and outpatient clinical services are provided separately by the geriatric service. The major specialized components of the Geriatric Service Unit are a Geriatric Day Treatment Program, a Home Evaluation Team, and a Residential Care Home Program. In addition, the Geriatric Service Unit component is linked to a number of services provided through the Council of Churches, including a Retired Senior Volunteer Program, Telephone Reassurance, a Senior Block Information Program, Senior Aide services to persons in their own homes, Senior Activity Centers, a Creative Retirement Program, and Friendly Visitors. Many of these services, plus linkages to a range of community health, legal, and social services, have been developed over the 22 years that the Council of Churches has had a program for the elderly. Thus, the Geriatric Service Unit was plugged into a well-established network of community services for the elderly.

The CMHC contract with the Geriatric Unit is for direct service only and does not include consultation and education. Some of the other units of the Council of Churches, however, often act as a consultant to community agencies interested in aging.

Model F—Evolution from a Geriatric Screening Unit

This Geriatric Program evolved from a State-funded demonstration project, begun in 1963, designed to determine if geriatric commitments to State hospitals from a west coast city could be served in a less drastic way. About 5 years later, the Geriatric Screening Project became part of the citywide community mental health program. In 1973, it became administratively attached to a single CMHC catchment area with a plan to serve a second catchment area until it could develop its own geriatric program. The other catchment areas in the city were requested to develop their own geriatric services. In 1976, it was decided that the Geriatric Program would continue to provide geriatric services to the two catchment areas.

Two major changes in the program of the original Geriatric Screening Unit evolved from this organizational attachment to a CMHC. Most referrals to the Geriatric Screening Unit had come from other parts of the city rather than from the area where it was located. Extensive community education and an outreach program with existing agencies in the area had to be carried out in order to make the service visible to the communities and community agencies within the catchment area. The services then became more comprehensive in nature; they were not just screening and referral.

The Geriatric Services Program has contacts with the administrators of the different services of the CMHC where it is based and works with them in certain situations, such as inservice training. Administratively, the director of the CMHC relates to the coordinators or directors of the various units of the Geriatric Services Program. Weekly staff meetings are held with each unit head. The Geriatric Services Program director also relates administratively to the various adult outpatient clinics, the day treatment programs, and to a subcontracted outpatient mental health clinic. The individual programs of the center are free to pursue their relationships with the area agency on aging; however, the area agency on aging provides no funds for geriatric services to the center. At various times, Geriatric Services Program staff have related to the health committee of the area agency on aging either for information or for particular planning issues. The area agency on aging is responsible for citywide planning and disbursement of available Federal funds for seniors and is trying to develop some needed programs, such as transportation, for the catchment area served by the Geriatric Services Program. The area agency on aging is also represented on the center's coordinating committee which enables the center to focus on larger issues related to the elderly, rather than only on mental health.

The Geriatric Services Program is physically located outside the catchment areas it serves and several miles from the one to which it is administratively attached. It does much of its work through the adult outpatient satellites and the day treatment programs of the two centers. Patients are followed and treated by the Geriatrics Services Program team from intake (often an emergency, involuntary evaluation) through inpatient or outpatient care to institutional placement, if necessary. Staff are assigned by the two mental health centers and are administratively responsible to the director of the Geriatric Services Program. From the time they are assigned, staff deal only with the Geriatric Services Program caseload. The satellites have no specifically designated geriatric staff. They do see some elderly patients. Consultation is provided by Geriatric Services Program staff on request. Most of the older patients in the satellites are referred directly to the Geriatric Services Program.

The Geriatric Services Program is included in the city public health/mental health budget. The core staff, derived from the original screening unit, are financed through the city/county budget, State/local mental health matching funds, and ad valorem taxes. Additional positions in the centers are funded from an NIMH staffing grant. None of the Geriatric Services Program positions, however, are Federal staffing grant positions; they all come from the county. There are also other staffing grants from the State mental health matching grant program in which the State pays 90 percent and the county pays 10 percent. Third-party payments may be collected from Medicare, Medicaid, or private insurance. However, all revenues go back into the general fund from which they are recycled in the next year's budget. The Geriatric Services Program positions are based on that general budget.

The Geriatric Services Program plans to establish a halfway house, using an NIMH Conversion Grant. Since this grant will have a limit of 2 years, it is hoped that, once a house is obtained and functioning, it will be self-sustaining, both by using the SSI rate for board and care reimbursement and by billing Medicaid for the clinical component. Some medical services might be reimbursable by Medicaid. The greatest expense will be the 24-hour staffing needed because the patients referred will be more disturbed than those in any board and care home.

The primary goal of the Geriatric Services Program is to keep the older person functioning in his own home for as long as possible. A secondary goal is to ensure appropriate and adequate care to those persons in need of placement. Flexibility in the kinds of direct service to a patient or on his behalf is crucial. The success of establishing a therapeutic relationship may hinge on a willingness by the staff to reach out and help with aspects not so specifically related to mental illness that cannot wait until the appropriate referral can be made. The crisis evaluation home visiting aspects of the Geriatric Services Program are the central element in their service program. These services are costly, time-consuming, and require skilled staff. To maintain these patients in their own homes, an extensive array of community support services is necessary. The Geriatric Services Program believes that home visits, despite their high cost, are far more useful than consultations after a person has been placed in an institution.

The Geriatric Services Program has made a special effort to recruit staff with different ethnic backgrounds and language abilities in order to improve communications with the minority elderly in the catchment areas.

Model G—Specialized Geriatric Services in an Established CMHC

The Geriatric Unit, "Positive Aging Services" (PAS), was developed over a period of 10 years and was designed to provide direct and indirect mental health services to the elderly within the catchment area of the CMHC where it is located. The elderly and chronically ill comprise over 18 percent of the total population in this Eastern metropolitan catchment area. The principles and basic assumptions underlying the program components are:

- The elderly are not a homogenous group.
- Old does not necessarily mean sick.
- There is a range of mental illness requiring a range of services.
- Active treatment is the appropriate and effective approach to mental health services for the elderly.
- Evaluation should be comprehensive and diagnosis accurate.
- Services must address the needs of the consumer, not of the provider.
- Service delivery should be structured to provide continuity of care.

Through systematic coordination of resources, the PAS program staff adapt service "packages" to recognize and support the special needs of the chronically ill and elderly. The organized service delivery system is continually evaluated and tested to improve access, to target service resources, and to facilitate appropriate use of services. Careful demographic and resource analysis of the separate neighborhoods within the catchment area contribute to identification of different needs, target groups, and program priorities. Variations in ethnic composition, economic levels, and settings in which the elderly are found (own home, residential care, long-term care facilities) make for modifications in program approaches and goals.

The core services range from minimal support and prevention (primarily through outreach activities) to active intervention, treatment, and support services (through home care, home health, and case management) to institutional care. The PAS program recognized the importance of a range of services and a varying intensity of services to promote the individual's maximum independent functioning in the least restrictive environment. Thus, the PAS programs directed toward support and treatment of the chronically ill and elderly, living either in the community or in institutions, are divided into direct and indirect services. The "scale of services" is ordered according to the intensity of service—from the least medically intensive support prevention services which are intended to maintain individuals in the community (such as information and referral services) to the most medically intensive treatment which is provided through day treatment programs or residential institutional programs (such as nursing homes). The overall goal of the PAS program is to provide a full range of clinical, diagnostic, referral, treatment, outreach, and mental health support services for persons living in the community as well as for those persons currently residing in institutional settings such as nursing homes.

The service is multidisciplinary, under the direction of a geriatric psychiatrist. Staff are assigned to broad program functions such as outreach, case management, day treatment, and consultation. Psychiatric treatment, including emergency services, full-time hospitalization, partial hospitalization, and outpatient therapies are available within the center. The center is a well-established training and research facility, and these interests are incorporated in the PAS program.

The primary source for funds for the support of the PAS program is the State Department of Mental Health. The Geriatric Unit functions as a specialized resource for this Department. Other sources of funds include an Administration on Aging model project grant, two foundation awards, Area Agency on Aging funds, and ACTION. The program also uses student placements as a resource. NIMH grants and contracts were a significant resource in the development of the program.

The Geriatric Unit PAS programs are designed to:

- Expand the scope of services which have been available in the catchment area in either institutional or community programs through outreach, aftercare, case management, home care, psychiatric evaluation and treatment, and general mental health services.

- Use active intervention to prevent or delay institutionalization of the chronically ill and elderly through organizing and coordinating community support services such as transportation, information and referral, and legal aid services.
- Take the lead as a resource center to increase continuity and accessibility in the services available to persons living in the community and in institutional settings.

To implement these concepts, the PAS program attempts to address mental health needs and services along a continuum from normal functioning and behavior for a given age cohort and cultural group to the clinical diagnosis of mental illness. Promoting homeostasis at any point along a mental health-mental illness continuum is the basis for structuring the organization and delivery of the Positive Aging Services. Accepting the continuum concept as the basis for overall program structure, PAS maximally uses and coordinates staff efforts and community resources to support each individual.

The entire staff work in a reactive environment concerned with the identification of specific activities which will be responsive to individual needs in an organized and consistent manner.

A major accomplishment of the PAS program was to raise the level of awareness of the mental health needs of the aged in the community and within institutional health care provider groups. PAS staff work to help all health care professionals accept the aging person's changing needs and behavior as expressions of an individual's personality which should not be blunted by stifling activities, regimentation, or medication.

C. Problems and Issues

The incremental approach to the development of community mental health services for the elderly is not without its problems and rough spots. Some of the problems reflect the issues and resistances that are inherent in the development and support of any community mental health service for any age group. Others are more specifically related to attitudes toward services for the elderly and policy or legislative limitations put on needed services. The Report of the President's Commission on Mental Health addressed many of these issues. If the proposed Mental Health Systems Act is passed by Congress, there will be several new ways in which development of mental health services for the elderly will be assisted.

Solutions to problems currently experienced by centers depend in large part on the skill, imagination, and administrative ability of the director or coordinator of the geriatrics mental health program. Problems which have posed difficulties for the program studied include:

1. Cash Flow. For example, billing of mental health services covered by a contract cannot take place until after the service has been given and books are closed for the month. Processing time at several governmental levels plus issuance time at the payment office has resulted in a 3-month delay from the time the service was given to the date the payment was received. These same delays occur in Medicare, Medicaid, and other third-party payment programs. Whenever possible, arrangements should be made for prospective reimbursement.
2. Variance in funding year to year. State and local appropriations, revenue sharing funds, and Title XX allocations change from year to year. State/local mental health revenue sharing (i.e., the Lanham, Petris Short Act in California) can provide some base of continuity in funding. One state has managed a continuity of Title XX funds for mental health by State legislation which mandates earmarking of Title XX funds for these purposes.
3. Limited scope of fee-for-service support. Most elderly have limited personal resources to pay fees and are unable to obtain services unless they are covered by Medicare or Medicaid or some other form of third-party payment. With a self-sufficiency fee-for-service operational concept, it is hard for a center to have adequate staffing to deliver all the services at a level needed by the elderly in the community. Consultation and educational activities are especially limited.
4. Limited support services. Many support services are limited to persons who qualify for Supplemental Security Income and Medicaid. Medicare covers few, if any, of the services needed to maintain the elderly in their own homes. Long-term nursing home care is unavailable through Medicare, and individuals must deplete their assets to Medicaid eligibility levels before receiving assistance with these costs. Home-attendant service and other health or nursing care costs are prohibitive for most persons not qualifying for financial or medical assistance.

5. Fiscal constraints affecting all publicly financed services. There is a ripple effect which reaches geriatric mental health services, whether the constraints have been placed on mental health services, social services, or other human service programs. One consequence in programs sponsored by public agencies is that trained staff are deleted or bumped out through the seniority process brought on by staff reductions. "Proposition 13" cuts in tax support mean a harder scramble for funds and shifting from those sources most likely to be cut to those left more intact.
6. Competition between age and disability groups. This is evident in the Title XX program where the statutory "cap" on what was once an open-ended funding arrangement brings out a lot of competition and political maneuvering between groups supporting services for children, drug addicts, the adult handicapped, and the elderly.
7. Limitations in health insurance coverage. Comprehensive mental health services are multidisciplinary in nature and require psychosocially oriented services as well as medically oriented services. The definitions and other limitations in both private and public health insurance make it difficult to provide all needed services.

IV. RESOURCES RELEVANT TO THE ELDERLY AVAILABLE FOR USE BY CMHC STAFF

A. Overview

This section of the guide describes major resources supported in whole or in part by Federal funds that are available to finance services needed by the aging person with mental health problems. In some instances, these sources of funds can be used to pay for services provided by the community mental health agency. In others, they pay for services provided by other community agencies. The relevance of these resources to the community mental health agency as a direct provider of services and to its patients and clients who need services provided by other agencies is summarized in table 1.

B. Description of Each Major Resource

Resources relevant to the elderly are administered by many different Federal, State, and local agencies. Each tends to have its own eligibility requirements, coverage of services, reimbursement requirements, limitation on benefits, and provider qualifications, although not all of the foregoing factors are applicable to each resource. The characteristics of the major resources which are supported in whole or in part by Federal funds are described in this section. There are State and local variations in the way some of these resources function in local communities; this will be noted where it exists, and users of this guide will need to learn about them in their own community.

Some of the resources included in this section make benefits available directly to the elderly individual. Others are resources made available to agencies to help them develop or enhance their services to the elderly person.

Table 1. Available Resources

Resource	Relevance to the patient or client	Relevance to the community mental health program
Health		
Medicare (Title XVIII)	Federal program that provides coverage for specified health care services for persons aged 65 and over and eligible disabled persons. Covers hospital and post-hospital skilled nursing home care and home health services. Subject to premiums, covers physicians and other specified outpatient services. Subject to certain limitations, covers psychiatric treatment.	CMHC can qualify as provider of care reimbursed by Medicare, if it is affiliated with a hospital that meets JCHA standards of accreditation for general or psychiatric hospitals or if it meets Medicare's condition of participation of a physician-directed clinic.
Medicaid (Title XIX)	Federal grants to States to cover 50–83 percent of costs of medical care for eligible low-income families and individuals. Within Federal guidelines, States establish eligibility, determine scope of benefits, and administer the program. Under Federal requirements, provision is made for inclusion of optional mental	CMHC must find out from State Medicaid agency or its local representative what specific requirements must be met to qualify as a reimbursable provider of care. CMHC must be familiar with provisions regarding mental health services in State Medicaid Plan and

	health benefits in psychiatric hospitals for persons over 65. Most Medicaid eligibles aged 65 and over are also covered under Medicare. In such cases, most State Medicaid agencies pay for Medicare premiums, deductibles, and coinsurance. Medicare makes primary payment for medical service.	can work with State Medicaid agency toward strengthening these provisions.
Aging (Older Americans Act)		For all aging programs:
State and community programs on aging: Social services	Formula grants to States to develop comprehensive and coordinated systems of social services to serve persons aged 60 and over. Support for program covers entire range of services including transportation and escort; outreach; health related; preventive (homemaker, home health, chore, friendly visiting, telephone reassurance, protective, housing); legal; nutrition; employment; recreational; information and referral; and others determined necesssary for the welfare of older persons.	CMHC must be familiar with State and area plans for programs on aging, particulary provisions regarding prevention, mental health services, and treatment. CMHC can plan joint service delivery and funding arrangements with area agency on aging.

Table 1.—Continued

Resource	Relevance to the patient or client	Relevance to the community mental health program
Multipurpose senior centers	State and area agencies on aging may award grants for acquiring, altering, or renovating or for the construction of a facility to serve as a multipurpose center, which is a community facility for provision of health, social, nutritional, educational, and recreational activities for persons aged 60 and over. State agencies can use Title III-B Social Services funds to construct centers in areas where no suitable structures are available. State can also use Title III-B money for personnel and operating costs of senior centers.	By working with State and area agencies on aging, CMHC has opportunity to influence scope of services included in their plans and make sure that mental health services are adequately covered.
Nutrition services	Formula grants are awarded through State and area agencies on aging to public and private nonprofit agencies to establish and operate low-cost group meals and home-delivered meals for persons 60 years and over	

	and their spouses of any age. Each project is required to provide meals in a congregate setting and offers supportive services including nutrition, education, and outreach.
Community service employment for older Americans	Secretary of Labor may contract with public and private nonprofit agencies to develop and administer part-time employment opportunities in public service activities for low-income persons aged 55 or older.
Demonstration projects	Federal project grants are awarded to public agencies or nonprofit private organizations to develop projects designed to demonstrate new or improved methods of providing needed services to older people, focusing especially on housing, transportation, education, preretirement counseling, and special services for older handicapped persons.

Table 1.—Continued

Resource	Relevance to the patient or client	Relevance to the community mental health program
Income Maintenance		
Supplemental Security Income	Provides monthly cash payments to persons with limited or no income who are aged, blind, or disabled. SSI is a federally funded, needs-tested income maintenance program. Most States supplement Federal payments.	CMHC can inform the patient of the availability of this resource, when appropriate, and help him use it.
Food Stamps	Low-income families and individuals are eligible to receive monthly food stamp allotments, varying with income and household size. Elderly may exchange food stamps for home-delivered meals. Elderly and certain disabled persons may use food stamps in certain congregate programs.	CMHC can inform the patient of the availability of this resource, when appropriate, and help him use it.
Social Supports		
Title XX - Social Services for low-income persons and public assistance recipients	Federal formula grants to State welfare agencies to establish and operate social service programs for individuals meeting State income	CMHC must negotiate "purchase of service" agreement with State Title XX agency in order to qualify as provider of services. This may be in

	limitations. Services for the elderly may include information and referral, home health care, day care, transportation, and mental health services.	form of negotiated contract with Title XX Agency or subcontract with State Department of Mental Health. CMHC must be familiar with State Title XX agency plan and work with this agency to include appropriate social supports and mental health services.
Housing:		For all housing programs:
Community development block grant	HUD provides formula grants to urban communities, based on poverty population and other economic and population factors, for variety of community development activities including construction of senior citizens centers.	Working out effective housing resources for different groups of the elderly, including the mentally handicapped elderly is essential if the CMHC is to provide alternatives to institutional care.
Low and moderate income housing – Section 8 rental subsidies	HUD provides housing assistance payments for low-income persons and families who cannot afford "decent and sanitary housing in the private sector." Rent supplements cover the difference between the community's fair market down to 15–25% of tenant's adjusted income.	

Table 1.—Continued

Resource	Relevance to the patient or client	Relevance to the community mental health program
Section 202 housing program for the elderly	Federal loans are made by HUD for construction of multifamily rental housing for elderly age 62 and over. Tenants may qualify for rent supplements under Section 8 program.	If the center wants to develop a congregate or a nonmedical residential program, Section 202 is a primary resource.
Housing:		
Low rent public housing	Local housing authorities receive Federal loans from HUD to aid in purchase, rehabilitation, leasing, or construction of multi-family housing for low income families, individuals age 62 and over, and handicapped persons. Housing designed for the elderly may have congregate dining rooms and other special features. Rents may not be more than 25% of the family's income.	

Mortgage insurance on rental housing for the elderly	Federal Government HUD insures against loss on mortgages for construction and rehabilitation of multifamily rental housing for elderly age 62 or over, or disabled, whose income is higher than low or moderate income level.
Rural rental housing loans	Farmers Home Administration (FmHA), Department of Agriculture, makes direct, and guaranteed insured loans to construct, improve or repair rental or cooperative housing in rural areas for low-income persons including senior citizens age 62 or over. Multifamily housing may have congregate dining and other congregate facilities.

Housing:

Rural rental assistance	FmHA provides rental assistance payments to low-income families in FmHA financed multifamily housing who would otherwise have to pay more than 25% of their income for rent.
Rural home repair program	FmHA makes loans and grants to low-income homeowners age 62 or over

Table 1.—Continued

Resource	Relevance to the patient or client	Relevance to the community mental health program
	to repair or rehabilitate their homes to remove dangers to their health and safety.	
Transportation:		For all transportation programs:
Reduced fares	Mass transportation companies that receive Federal funds from Department of Transportation (DOT) for either capital or operating expenses must charge elderly and handicapped persons no more than half fare during off-peak hours.	Cooperative agreements can be made between area agency on aging and CMHC to use vans for transporting elders to CMHC and other sites where they receive services.
Capital and operating assistance grants	DOT awards grants to local public agencies under Section 3 of Urban Mass Transportation Act for acquisition and construction of mass transit vehicles; under Section 5 for capital and operating expenses; and under Section 9 for planning. These grants may be used for special services for the elderly.	

Capital assistance grants for use by: – public agencies – private nonprofit groups	Under Section 16(B)(1) of Urban Mass Transportation Act, up to 2% of annual allotment for capital assistance grants may be set aside for local public agencies for acquisition of transit vehicles, equipment, and facilities. Grants may be used to meet special transportation needs of elderly. The 2% funding limitation also applies to private nonprofit agencies under Section 16(B) (2) which says that 2% of annual allotment for capital assistance grants may be set aside for private nonprofit groups to provide mass transportation services for elderly persons.	
Employment and volunteers:		For all employment and volunteer programs:
Employment programs for special groups	Under Comprehensive Employment and Training Act (CETA), Secretary of Labor may establish and operate training and employment programs for special groups, including older workers.	

Table 1.—Continued

Resource	Relevance to the patient or client	Relevance to the community mental health program
Community based employment and training programs	Under CETA, funds are distributed to "prime sponsors" (States, units of local government with populations of 100,000 or more) for providing work and training opportunities for persons of all ages wanting employment.	Centers make effective use of CETA employees and volunteers for manning outreach, telephone reassurance, companionship, and other social supports that make mental health services more effective.
Volunteers in Service to America (VISTA)	ACTION provides volunteer service opportunities for persons age 18 or older in urban and rural poverty areas, on Indian reservations, with migrant families, and in federally assisted institutions for mentally ill and mentally retarded. Most older VISTA volunteers serve part-time.	

Senior Companion Program	ACTION awards grants to public and private nonprofit agencies for creating volunteer service opportunities for low-income persons age 60 and over who wish to render supportive service to adults, usually senior adults. Volunteers receive $1.60 per hour.
Retired Senior Volunteer Program (RSVP)	Federal grants are made to public or private nonprofit agencies to establish or expand volunteer activities for the elderly; compensation for out-of-pocket expenses incidental to their services is provided.
Foster Grandparent Program	Federal grants are awarded to public and private nonprofit agencies for creating volunteer service opportunities for low-income persons, age 60 and older, to render supportive services to children. Volunteers receive $1.60 per hour.

The major resources are grouped under four headings: general health care programs; community and social support programs; aging programs; and mental health programs.

1. General Health Care Programs

This group of resources includes those available to the general population and certain special population groups to meet needs for all types of health care, including mental health care.

Medicare (Title XVIII of the Social Security Act, as amended) (Health Insurance for the Aged and Disabled)

Relationship of Medicare to Community Mental Health Centers. Medicare covers almost the entire population aged 65 and over and pays for a broad range of health care including mental health care. The community mental health center can be the provider of mental health care and receive reimbursement within certain constraints.

What It Is. Medicare is a health insurance program for persons 65 years and older and some people under 65 who are disabled. It is an exclusively Federal program. It has two parts: Part A—Hospital insurance which covers hospitalization and related care; Part B—Medical insurance which covers physicians' care and other health services. Together the two parts are known as "Health Insurance for the Aged and Disabled." Title XVIII of the Social Security Act contains the basic law governing these programs.

Part A—hospital insurance is funded through Social Security payroll tax deductions. It is designed to help pay for inpatient hospital care and, after a hospital stay, for inpatient care in a skilled nursing facility and for home care provided by a home health agency.

Part B—medical insurance is funded through subscribed monthly premiums paid by or in behalf of beneficiaries, matched by Federal contributions from general revenues and funds realized from certain deductibles and cost-sharing provisions. It is designed to help pay for physicians' services, outpatient hospital services, outpatient physical therapy and speech pathology services, and other medical services and supplies that are not covered by the hospital insurance part of Medicare. Part B medical insurance can also pay for home health services.

How It Works. At the Federal level the Social Security Administration, Bureau of Health Insurance, DHEW, had responsibility for administering Medicare from its inception in 1966 until 1977. At that time, the new Secretary of DHEW placed Medicare and Medicaid into a new organizational entity called the Health Care Financing Administration.

Since eligibility for Medicare depends upon eligibility for Social Security Old Age, Survivors, and Disability Insurance Benefits, Medicare eligibility questions and applications for benefits have been handled by local district Social Security offices from the beginning of the program. The Social Security office continues to serve as focal point for interrelationships between the Medicare beneficiary and the organizations which administer and operate the Medicare program.

Medicare payments are handled by private insurance companies which for Part A are called "intermediaries" and for Part B are called "carriers." Part A intermediaries are selected by the Part A providers—hospitals, skilled nursing facilities, and home health agencies—and are generally local Blue Cross agencies. DHEW designates which Part B carriers will administer the physician and outpatient services under Part B, such as local Blue Shield organizations and other private insurance carriers. For each provider of medical care in a given geographic location there is only one intermediary and one carrier.

Who Can Provide Services. Hospitals, physicians, treatment centers, skilled nursing facilities, home health agencies, and other persons or organizations providing services to Medicare beneficiaries must be approved for participation in the Medicare program.

To be eligible for participation in the Medicare program, a provider must satisfy statutory requirements of Title XVIII and regulatory requirements established by the Secretary of DHHS. These requirements, which have been established separately for each category of providers, are known as conditions of participation.

The Health Care Financing Administration (before them, the Social Security Administration) contracts with State agencies to examine and certify whether or not a provider complies with the conditions of participation. Preparation of a State agency report is based on an onsite survey. Where applicable, accreditation surveys are conducted by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Who Can Provide Mental Health Services. Some CMHCs could qualify as Medicare providers as *physician-directed clinics*. The conditions of participation for physician-directed clinics are as follows:

1. A physician or a number of physicians are present to perform medical (rather than administrative) services at all times the clinic is open.
2. Each patient is under the care of a clinic physician.
3. Nonphysician services are provided under medical supervision.

Who Is Eligible. The following persons are eligible for Part A—hospital insurance:

- All people age 65 and older entitled to monthly Social Security (SS) retirement or survivor or Railroad Retirement (RR) benefits are eligible.
- Certain persons who are 65 and older and not eligible for SS or RR benefits, or not covered, may be "deemed insured" under certain rules, established by DHHS, tied to age and quarters of Social Security coverage. These persons must be U.S. residents and U.S. citizens or aliens lawfully admitted for permanent residence with 5 years continuous residence.
- Persons 65 and older who do not qualify under either of the above and who meet citizenship and residence requirements may voluntarily enroll in Part A and must pay a monthly premium.
- Persons any age entitled or deemed entitled to disability based benefits for the 24 preceding months are eligible.
- Certain persons of any age with chronic renal disease requiring transplant or dialysis are eligible.

Persons entitled to Part B—medical insurance included:

- All people entitled to Part A are eligible.
- People age 65 and older who are residents of the United States and are either U.S. citizens or aliens lawfully admitted for permanent residence with 5 years of continuous residence are eligible.

The following rules apply to the above two eligible groups:

- Eligible people have automatic enrollment in Part B, unless they specifically decline it.
- An enrollment request is necessary by the person who (a) is not already an SS or RR beneficiary; or (b) has previously declined Part B; or (c) has terminated Part B.

- Entitlement is not retroactive.
- All persons entitled to Part B pay a monthly premium (or have it paid on their behalf).

Some inpatient services provided by CMHCs may be covered under Part A, but most services would be covered under Part B. Therefore, CMHCs should be primarily concerned with the eligibility of their clients under Part B. It is important to remember that this eligibility is restricted to the individual. His dependents and other members of his family are not covered.

The enrollment provision of Part B imposes a requirement of paying a monthly premium. As in any insurance program, coverage lapses if the monthly premium is not paid. Although payment is automatically deducted from the monthly Social Security check for those who elect to enroll, the often precarious budgets of the elderly may tempt them to forego enrollment or to disenroll, when financial circumstances become strained. Under current regulations, reenrollment following a lapse is circumscribed by a waiting period and by having only certain periods when reenrollments are accepted. Centers cannot assume that a client, once eligible for Part B benefits, is eligible continuously thereafter. The client's eligibility should be confirmed. If he is not eligible, the client should be helped to regain his covered status.

If the Medicare recipient is also eligible for Medicaid benefits because of poverty, the Medicaid agency will usually pay the Medicare premium. Federal law requires State agencies to be sure that all Medicaid recipients eligible to enroll in Part B do so. Almost all States pay the premiums in order to assure Part B enrollment. The penalty for a State failing to assure Part B enrollment is the loss of Federal money for all services which would have been covered by Medicare had the individual enrolled.

How To Apply. The individual who wants to apply for Medicare goes to the nearest Social Security office.

What Is Covered by Part A—Hospital Insurance. Medicare hospital insurance helps pay for three kinds of care: (1) inpatient hospital care and, when medically necessary, care after a hospital stay, (2) inpatient care in a skilled nursing facility, and (3) home health care.

There is a limit on how many days of hospital or skilled nursing facility care and how many home health visits Medicare can help pay for in a "benefit period." The coverage is limited as follows: Hospital care is paid for up to 90 days per "benefit period." Skilled nursing facility (SNF) services are limited to 100 days per "benefit period." Home health care services are limited to 100 visits per "benefit period." A "benefit period" is a way of measuring the individual's use of services under Medicare hospital insurance. An individual's first benefit period starts the first time he enters the hospital after his hospital insurance begins. When he has been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days (including the day of discharge), a new benefit period starts the next time he goes into the hospital. There is no limit to the number of benefit periods he can have.

In addition to the 90 days of hospital care per benefit period, each Medicare beneficiary is allowed 60 days of hospital care as a "lifetime reserve" from which he may draw, if a given period of hospitalization extends beyond 90 days. But unlike the 90 days of hospital care which become available with each new benefit period, the 60-day lifetime reserve is not renewable. Once a beneficiary uses a reserve day, he never gets it back.

Care in a Psychiatric Hospital. Medicare hospital insurance can help pay for no more than 190 days of care in a participating psychiatric hospital during the Medicare beneficiary's lifetime. Once the beneficiary has used these 190 days, hospital insurance cannot pay for any more care in a psychiatric hospital, even if he has some or all of his reserve days left.

In addition, there is a special rule that applies if the Medicare beneficiary is in a participating psychiatric hospital at the time his hospital insurance starts. The days he was an inpatient in the 150 days before his hospital insurance started must be subtracted from the days he could otherwise use in his benefit period for inpatient psychiatric care.

Inpatient Hospital Care. Medicare hospital insurance can help pay for inpatient care, if *all* of the following conditions are met:

1. A doctor prescribes inpatient hospital care for treatment of the individual's illness or injury.
2. The individual requires the kind of care that only can be provided in a hospital.
3. The hospital is participating in Medicare.
4. The Utilization Review Committee of the hospital or a Professional Standards Review Organization (PSRO) does not disapprove the individual's stay. (Review of hospital admissions must be performed within 1 day of admission. Medicare will not cover the cost of any services provided more than 3 days

after the institution has received notice of an adverse review decision.)

Inpatient hospital care *includes:*

- Up to 90 days per "benefit period" (renewable in subsequent benefit periods) plus 60 days "lifetime reserve" (nonrenewable) in a "participating" hospital
- Psychiatric hospital care (190 days lifetime limit)
- Semiprivate room and board
- Operating room
- Special care units
- Recovery room
- Drugs, medical supplies and appliances furnished by hospital
- Laboratory tests, X-ray, and radiological services
- Rehabilitation services
- Medical social services
- Emergency services (can also be covered in nonparticipating hospitals under certain conditions)

Inpatient hospital care *excludes:*

- Services not reasonable and necessary for diagnosis and treatment of illness or injury
- Personal comfort items (such as television, radio, or telephone)
- Private duty nurses
- Private room (unless medically necessary)
- Physicians' services (may be covered under Part B)
- Noncovered level of care

Inpatient Care in a Skilled Nursing Facility. For purposes of Medicare, a skilled nursing facility is a specifically qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services as well as other related health services. In some facilities, only certain portions participate in Medicare.

A CMHC is not a qualified provider of inpatient skilled nursing care under Medicare.

Hospital insurance can help pay for care in a skilled nursing facility, if *all* of the following conditions are met:

1. The individual has been in a hospital at least 3 consecutive days, not counting the day of discharge, before his transfer to a participating skilled nursing facility.
2. The individual was transferred to the skilled nursing facility because he requires care for a condition which was treated in the hospital.

3. The individual is admitted to the facility within a short time, generally within 14 days after he leaves the hospital.
4. A doctor certifies that the individual needs and actually receives skilled nursing or skilled rehabilitation services *on a daily basis.*
5. The facility's Utilization Review Committee or a PSRO does not disapprove the individual's stay.

Inpatient care in a skilled nursing facility *includes:*

- Up to 100 inpatient days in a participating skilled nursing facility (SNF) per benefit period
- Semiprivate room and board
- Regular nursing services
- Drugs, medical supplies, and appliances furnished by the SNF
- Therapy (physical, occupational, speech)
- Medical social services

Inpatient care in a skilled nursing facility *excludes:*

- Services not reasonable and necessary for diagnosis or treatment of the illness or injury
- Personal comfort items
- Private duty nurses
- Private room (unless medically necessary)
- Physicians' services (may be covered under Part B)
- Noncovered level of care

Home Health Care. Medicare hospital insurance can pay for home health visits, if *all* of the following six conditions are met:

1. The beneficiary was in a qualifying hospital for at least 3 days in a row, not counting the day of discharge.
2. The home health care is for further treatment of a condition which was treated in a hospital or SNF.
3. The care needed by the beneficiary includes part-time skilled nursing care, physical therapy, or speech therapy.
4. The beneficiary is confined to his home.
5. A doctor determines that the beneficiary needs home health care and sets up a home health plan for him within 14 days after his discharge from the hospital or participating SNF.
6. The home health agency providing services is participating in Medicare.

A CMHC is not a qualified provider of home health care under Medicare.

Home health care *includes:*

- Up to 100 visits from a participating home health agency after start of one benefit period and before start of next
- Part-time nursing care
- Therapy (physical, occupational, speech)
- Part-time services of home health aides
- Medical supplies and appliances furnished by the home health agency
- Medical social services

Home health care *excludes*:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury
- Full-time nursing care
- Drugs and biologicals
- Personal comfort items
- Meals delivered to the home
- Homemaker services
- Physicians' services (may be covered under Part B)
- Noncovered level of care

What Is Covered by Part B—Medical Insurance. Medicare medical insurance can help pay for physicians' services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health services (in addition to that available under Part A), and other health services and supplies which are not covered by Medicare hospital insurance.

Home health care benefits under Part B are limited to 100 visits in a calendar year and are entirely separate from the 100 visits allowable under Part A. Part B has the same requirements as Part A except prior hospitalization is not required.

Outpatient Psychiatric Treatment. Physicians' services received by a beneficiary for outpatient treatment of a mental illness are covered, *but* the maximum amount medical insurance can pay for these services is $250 in a year. This is a severe limitation on the extent to which outpatient psychiatric services are available to beneficiaries under Part B.

Medicare medical insurance *includes* physicians' services (and services and supplies furnished incident to a physician's professional service) and outpatient hospital services including:

- Incident to physician's services

- Diagnostic and therapeutic services provided by a participating hospital (for emergency services may sometimes be by nonparticipating hospital)
- Diagnostic tests, including X-ray and laboratory tests
- Therapy including X-ray, radium, radioactive isotope
- Outpatient physical therapy and speech pathology by a participating hospital, SNF, home health agency or approved clinic, rehabilitation agency, or public health agency
- Coverage of services of independently practicing physical therapists (up to $100 of reasonable charges per calendar year)
- Certain ambulance services
- Home health services—up to 100 visits in a calendar year
- Prosthetic devices replacing all or part of an internal body organ, including prosthetic eyeglasses and contact lenses which replace the lens of the eye removed during cataract surgery
- Braces for arm, leg, back, neck
- Artificial arms, legs, eyes
- Other medical supplies, such as splints, casts
- Limited chiropractic services
- Durable medical equipment for use in patient's home (rental or purchase), including home dialysis equipment and supplies
- Chronic renal disease facility care by approved suppliers of maintenance dialysis services

Medicare medical insurance *excludes:*

- Items and services not reasonable and necessary for diagnosis or treatment of illness or injury
- Prescription drugs
- Routine physical check-ups
- Hearing aids, eyeglasses and examination for fitting them (exception: see prosthetic devices above)
- Dental services (treatment, filling, removal, or replacement of teeth)
- Routine and certain other foot care
- Orthopedic shoes (unless part of a leg brace) and other supportive devices for the feet
- Immunizations (except where immediate risk of infection)
- Cosmetic surgery

What It Costs the Beneficiary. Since Medicare is considered a health insurance program, it includes several types of cost sharing which are typical of health insurance systems: premiums, deductibles, and copayments or coinsurance.

A premium is a monthly amount which must be paid by or on behalf of the health insurance beneficiary if he is to be covered by the insurance and receive any benefits from it.

A deductible is a fixed sum which a health insurance beneficiary must pay each year before the health insurer will pay anything toward the cost of his medical expenses.

Coinsurance is a fixed sum or percentage which the beneficiary must pay toward the cost of each medical or health service received. The insurer will pay only the amount of the bill less the beneficiary's coinsurance amount.

The following list shows cost-sharing information for Medicare as of July 1, 1979. By law, some of these cost-sharing provisions are determined each year by the Secretary of DHHS, according to the current cost of providing medical care, but with certain limitations. For example, the annual adjustment of the Part B medical insurance premium may not exceed the percentage increase in Social Security payments for that year.

For Part A—Hospital Insurance:

Premium: None, except for individuals 65 and older not otherwise eligible for Part A. For them the amount is $69 a month (as of July 1, 1979).

Inpatient Hospital Care.

Deductible: From 1st day through 60th day of inpatient hospital care, beneficiary pays first $160 per benefit period (as of January 1, 1979).

- Amount is determined each year by Secretary of DHHS.

It approximates the national average cost of a 1-day hospital stay. Changes are effective for benefit periods beginning on or after January 1.

Coinsurance: From 61st day through 90th day of inpatient hospital care, beneficiary pays $40 per day.

- Equals one-fourth of inpatient hospital deductible. For each lifetime reserve day beneficiary uses, he pays $80 per day.
- Equals one-half of inpatient hospital deductible.

Skilled Nursing Facility Care.

Coinsurance: From 21st day through 100th day of SNF care, beneficiary pays $20 a day.

- Equals one-eighth inpatient hospital deductible.

Home Health Care

No deductible or coinsurance.

For Part B—Medical Insurance:

Premium: $8.70 a month (as of July 1, 1979)

- Any change effective for 12-month period, beginning July 1.

Deductible: Beneficiary pays first $60 of covered charges in each year.

Coinsurance: Beneficiary pays 20 percent of additional covered charges incurred during rest of year.

Exceptions to the Above.

- For inpatient services of pathologists and radiologists, no deductible or coinsurance.
- For outpatient physician treatment of mental illness, only 62½ percent of reasonable charges (maximum of $312.50 per calendar year) may be allowed for benefit computation; after subtraction of any unmet deductible, the benefit is 80 percent of this adjusted amount. In effect, this limits the amount that Medicare can pay for these services to $250 in any one year.
- For Part B home health services, deductible applies but not coinsurance.

What Are the Reimbursement Rates? Part A providers are reimbursed on the basis of "reasonable costs" which generally approximates the provider's actual cost. Institutions providing services under Part B are also reimbursed on the basis of "reasonable cost." Under Part A, the provider receives the payment. The provider must accept the Medicare payment as full payment and may bill Medicare recipients only for deductibles and copayment.

Individual medical vendors, such as physicians or other practitioners, are reimbursed under Part B on the basis of "reasonable charges" which are not determined on the basis of cost, but are limited to the lower of: (1) the customary fees of the individual practitioner, and (2) the 75th percentile of the prevailing charges for the same or similar service in the practitioner's community. Part B practitioners, whose charges to private patients are often much higher than allowable under Medicare, may bill Medicare patients the difference between their private charges and the Medicare allowable charges. However, if the Part B practitioner "accepts an assignment' of the claim from the Medicare beneficiary, the practitioner *must* accept the Medicare allowable charge as full payment and may bill the Medicare beneficiary only for the deductibles and copayment.

Where To Go for More Information. Social Security Office.

Medicaid (Title XIX of the Social Security Act, as amended)
(Grants to States for Medical Assistance Programs)

Relationship of Medicaid to CMHCs. Under the Medicaid program, CMHCs can provide and receive reimbursement for costs of treatment of Medicaid eligibles, including persons who are receiving Supplemental Security Income and other persons who have low income.

What It Is. Title XIX of the Social Security Act, commonly known as Medicaid, provides for a program of medical assistance for certain low-income individuals and families. Medicaid does not provide medical assistance to all of the poor. Low income is only one test of eligibility. Resources are also tested. And most importantly, an individual must belong to one of the groups designated for Welfare eligibility to be covered. Unlike Medicare, in which the Federal Government makes payments to all eligible citizens or to the suppliers of their medical services, Medicaid operates through a program of Federal assistance to the States. Medicaid is a State-administered program. Within the framework of the Federal law, each State decides if it wants the program, what services will be provided, and to whom.

Each State participating in Medicaid is required to have a designated single State agency to handle the administration of the program and to prepare an annual State Medicaid plan specifying the categories of persons eligible and the services covered. The plan is subject to review and approval by the Secretary of DHHS. The State agency in most States is the welfare department.

How It Works. Medicaid is financed jointly with State and Federal funds. The non-Federal share can be financed entirely out of State funds or can be jointly financed by the State and local governments, with State funds accounting for not less than 40 percent of the non-federal share. The Federal Government matches funds for costs of services to each State on the basis of a formula which considers State per capita income. The current Federal contribution to the cost of the program ranges from 50 percent to the richest States to 78 percent to the State with the lowest per capita income. All States except Arizona participate in the Medicaid program.

Medicaid basically is administered by each State within certain broad Federal requirements which allow for variations in benefits offered, groups covered, income standards, and levels of reimbursement for providers. This means that Medicaid varies greatly from State to State.

Who Can Provide the Mental Health Services. A CMHC must meet State Medicaid standards in order to receive Medicaid reimbursements. The Federal Government simply requires that the State Medicaid plan specify the criteria and procedures for determining which providers should participate in Medicaid. The State itself has complete responsibility for determining the criteria and procedures for approving providers—licensure or certification.

In a survey conducted by the National Council of Community Mental Health Centers, about 80 percent of the responding centers stated that they participate in Medicaid programs. If a center has not established an agreement with Medicaid, it should get in touch with the State Medicaid agency to determine what specific requirements must be met to qualify as a reimbursable vendor.

Who Is Eligible for Services. Two major groups of people are eligible for Medicaid:

1. *Categorically needy*—includes all persons receiving Aid to Families with Dependent Children (AFDC) and either all aged, blind, and disabled persons receiving Supplemental Security Income (SSI) or those who can meet additional more restrictive State Medicaid eligibility conditions.
2. *Medically needy*—includes people who fit into one of the categories of people covered by cash welfare programs, who have incomes higher than the maximums allowable under the State cash Welfare programs but who cannot afford to pay for their medical care.

States generally determine the eligibility level for the Welfare programs. They set the AFDC level and determine the amount of supplement, if any, to the basic Federal SSI payment. Therefore, they exercise a great deal of control over the income eligibility levels for Medicaid.

Many Medicaid eligibles are aged or disabled and are also covered under Medicare. In cases where dual coverage exists, most State Medicaid programs pay for the Medicare premiums, deductibles, and copayments, and for services not covered by Medicare.

How To Apply. The individual who needs to find out where to apply for Medicaid can telephone the Welfare office.

What Services Are Covered. Title XIX requires that States must provide for all of the following services to the categorically needy:

1. Inpatient hospital services other than those in an institution for tuberculosis or mental disease
2. Outpatient hospital services and rural health clinic services
3. Laboratory and X-ray services
4. Skilled nursing facility and home health services for individuals 21-years-old and over
5. Physicians' services
6. Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) for individuals under 21
7. Family planning services

In addition, States may provide and receive matching funds for the following optional services:

- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy; occupational therapy; and treatment of speech, hearing, and language disorders
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses
- Other diagnostic, screening, and rehabilitative services
- Inpatient hospital services, SNF services, and ICF services for persons 65 or over in institutions for tuberculosis and mental diseases
- ICF services, including ICF services for the mentally retarded in institutions other than tuberculosis hospitals, or mental institutions for persons determined to be in need of such care as specified in the Social Security Act
- Inpatient psychiatric services for those under 21
- Any other type of medical or remedial care recognized under State law and specified by the Secretary of DHHS. This may include a range of services of licensed practitioners, e.g., optometrists and chiropractors.

Optional services which are promising possibilities for reimbursement to CMHCs are clinic services; diagnostic, screening, preventive, and rehabilitative services; prescription drugs; and care for patients 65 years or older in institutions for mental diseases.

Some states have included specific mental health services in their State Medicaid plans. Examples are:

- Clinic services under the supervision of a psychiatrist
- Psychiatric and psychological services

- Clinical psychologists' services
- Mental health services
- Physician-directed mental health clinics
- Community mental health services
- Psychological evaluation and/or treatment
- Psychiatric care

States can impose limitations on their coverage of both mandatory and optional services, such as limitations on the number of days of care for inpatient services, and limitations on the number of outpatient visits. A State may set a limit on the number of times a service will be reimbursed for a particular patient. For example, a State may reimburse a CMHC for a maximum of two individual therapy sessions per month per patient. The State may set a dollar limit per patient and may require prior authorization for certain services.

A CMHC should be thoroughly familiar with its State Medicaid plan and should know what mental health services are covered within it, as well as what restrictions, if any, are placed on them.

It is well to keep in mind that States can alter their Medicaid programs at any time with Federal approval as long as their programs remain within the Federal guidelines.

What Are the Reimbursement Rates. The Medicaid program is not designed or required to meet the full cost of health care for those who are eligible for its services, although rates of reimbursement usually cover the large share of the cost incurred. Payments are made directly to the provider of service for care rendered to an eligible individual. Providers must accept the Medicaid reimbursement level as payment in full.

In setting reimbursement rates, States must establish upper limits for each type of covered service. Inpatient hospital services must be reimbursed at the upper limit, but all other services may be reimbursed at the limit or at lesser amounts. Two methods are used to determine upper limits:

1. Reasonable cost—a term borrowed from the Medicare program—is related to the cost actually incurred by a provider in providing service. It may be calculated on a per unit of service, per diem, per capita, or other basis. Use of this method indicates that the provider has an accounting system that can provide actual cost information.
2. Reasonable charge—a term also taken from the Medicare program—is the more common basis for negotiating rates with clinics and physicians. Charges are established for classes of

providers, taking into consideration the *customary charges* for similar services generally made by that specific provider, and the *prevailing charges* for similar services made by most providers in the area.

What Are the Cost-sharing Provisions. States may impose certain cost-sharing requirements under their Medicaid program. The law specifies that no cost sharing can be imposed on the mandatory services for cash assistance recipients but allows States to impose "nominal" cost-sharing requirements on optional services for cash assistance recipients and on any services for the medically needy.

A CMHC should find out what cost-sharing provisions, if any, have been established in the State that might affect potential reimbursement of services provided by the center. If the center is expected to charge the client for part of the services provided, Medicaid will pay only the balance.

It should be noted that all States require Medicaid patients in long-term care institutions to contribute their excess income (generally all income over the $25 monthly they require for personal needs) to help pay for the cost of their care. Similarly, all medically needy individuals who have income that exceeds the amount set for Medicaid eligibility must use their excess income to pay for their medical care, until they have reached the Medicaid level.

Excluding Grant Funds from Rate Calculations. Some States require that NIMH categorical grant funds must be deducted before calculating the cost of Medicaid services.

Where To Go for More Information. State Medicaid Agency. See Appendix E.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

Relationship of CHAMPUS to Community Mental Health Centers. For CMHCs located in areas where there are concentrated numbers of active duty or retired military personnel, CHAMPUS can be a significant resource for third-party payments for services which the CMHCs provide to persons eligible for CHAMPUS benefits. The important limitation is that, except for spouses and children of active duty members, loss of CHAMPUS eligibility is automatic at age 65 when persons become eligible for Medicare.

Two other limitations are: (1) If a Uniformed Service Hospital is within a 40-mile radius of the patient's residence, he cannot get benefits under CHAMPUS unless he gets a Nonavailability Statement from the hospital; (2) written preauthorization must be obtained by the patient in order for CHAMPUS to provide certain kinds of medical services, including services from a specialized treatment facility.

What It Is. CHAMPUS is a medical benefits program provided by the Federal Government to help pay for civilian medical care rendered to retired members of the Uniformed Services, their dependents, and dependents of active duty and deceased members. Active duty military themselves are not eligible.

In general, members of the Uniformed Services and their dependents obtain their medical care from Uniformed Services medical facilities. Recognizing, however, that care is not always available from such facilities and that many beneficiaries do not live near one, the CHAMPUS program was established by the Federal Government to provide medical benefits from civilian sources with the government sharing the cost.

How It Works. CHAMPUS is managed and operated by the Office of Civilian Health and Medical Programs of the Uniformed Services (OCHAMPUS) located in Denver, Colo.

OCHAMPUS contracts with various organizations to process and pay claims for medical care. These organizations are called CHAMPUS Contractors and include, for example, Blue Cross, Blue Shield, Mutual of Omaha, other private insurance companies, and State medical societies.

Who Can Provide the Mental Health Services. Civilian physicians, clinical psychologists, inpatient facilities, and outpatient facilities may participate as providers, if they meet the requirements and standards of CHAMPUS. In addition, psychiatric and clinical social workers are CHAMPUS-authorized providers, if the patient is referred to them by a physician who also provides supervision.

Who Is Eligible for Services. The following categories of persons are eligible for CHAMPUS:

- Spouses and children of active duty members of the Uniformed Services
- Retired members of the Uniformed Services
- Spouses and children of retirees
- Unremarried widowers and widows, and children of deceased active duty members and deceased retirees.

The Uniformed Services to which CHAMPUS applies are the Army, Navy, Marine Corps, Air Force, Coast Guard, Commissioned Corps of the U.S. Public Health Service, and Commissioned Corps of the National Oceanic and Atmospheric Administration.

How To Apply. Eligibility for CHAMPUS benefits is determined by the Uniformed Service of which the active duty sponsor is a member or the retiree was a member.

A currently valid Uniformed Services Identification and Privilege Card (ID) is required to establish eligibility for CHAMPUS benefits. The ID card can be issued by any Service.

Active duty members and retirees apply to their own Service for ID cards for their spouses and children. Spouses and children of deceased active duty members and deceased retirees apply to the Uniformed Service of which the deceased was a member.

What Services Are Covered. CHAMPUS will cover most of the services provided by a CMHC, including individual and group therapy, inpatient medical care, outpatient care, partial hospitalization, emergency services, and prescription drugs.

Inpatient and outpatient benefits for psychiatric services are generally limited to a specific number of sessions per 7-day period. Outpatient benefits are limited to a maximum of two outpatient psychotherapy sessions per week, except that CHAMPUS may approve benefits under unusual circumstances for additional sessions on the basis of individual consideration.

All outpatient psychotherapy will be automatically reviewed and evaluated for continuation of benefits after the 8th and 24th sessions or more frequently if warranted by circumstances. Any treatment may be referred for medical review. Any treatment that extends beyond 60 sessions will be automatically referred for such review.

What It Costs the Beneficiary. The CHAMPUS beneficiary does not pay any premium.

Outpatient deductible—A CHAMPUS beneficiary is responsible for the first $50 of CHAMPUS-determined reasonable costs/charges for covered outpatient services and supplies during any fiscal year (October 1 through September 30). The total outpatient deductible amount for two or more beneficiary members of the same family who submit claims during the same fiscal year is $100.

There is no deductible for inpatient care.

Outpatient copayment for active duty spouses and children—CHAMPUS pays 80 percent—determined reasonable charge for covered services and supplies received by spouses and children of active duty members after the deductible has been met. The beneficiaries are responsible for the remaining 20 percent.

Inpatient copayment for active duty spouses and children—There is a copayment each time an eligible spouse or child of an active duty member is admitted to a civilian hospital or other authorized institution. That amount is $25 or the total amount that would have been charged if the admission had been to a Uniformed Service medical facility. (Note: The amount charged for inpatient care at Uniformed Services medical facilities changes each year. As of January 1, 1978, the amount was $4.40 per day.) The copayment amount must be applied to each individual admitted as an inpatient.

Inpatient copayment for other than active duty spouses and children—For retirees, spouses and children of deceased active duty members, and spouses and children of deceased retirees, the copayment is 25 percent of the reasonable cost/charge for covered medical care incurred during each confinement in a civilian hospital or other authorized institution.

What Are the Reimbursement Rates. The amount paid by CHAMPUS for a covered medical service or supply is based on the reasonable cost/charge for the particular service or supply as determined by the CHAMPUS contractor that processes the claim.

A Note about CHAMPUS and Medicare. Entitlement to Medicare benefits at any age affects the availability of CHAMPUS benefits.

For spouses and children of active duty members, Medicare is always primary (first pay), and the Medicare "lifetime reserve" must be used before CHAMPUS benefits are payable. Medicare entitlement, however, does not result in loss of CHAMPUS eligibility for spouses and children of active duty members.

When any individual retiree, spouse and child of retiree, and spouse and child of deceased active duty member and deceased retiree become entitled to Medicare, eligibility ceases for all CHAMPUS benefits.

Where To Go for More Information.

- The nearest CHAMPUS Advisor/Health Benefits Advisor (the person located at a Uniformed Service Medical facility who is authorized to give information on CHAMPUS)
- OCHAMPUS, Denver, Colo. 80240
- The CHAMPUS contractor serving the area where the CMHC is located

CHAMPVA (Civilian Health and Medical Program of the Veterans Administration)

Under a Veterans Administration program, CHAMPVA, spouses and children of veterans with 100 percent service-connected disability and survivors of those who died of service-connected causes are eligible for benefits parallel to CHAMPUS.

Information on CHAMPVA may be obtained from the nearest Veterans Administration medical facility.

Veterans Administration

Relationship of Veterans Administration (VA) Programs to CMHCs. Veterans will comprise the major portion of the aged population of men for the remainder of this century. The VA is therefore expanding the geriatric and community care aspects of its health care program. The VA's physical health and mental health personnel are being encouraged to find ways to collaborate with community mental health program staffs, for example, in resource development activities, information and referral programs, and staff development programs.

If a VA hospital is located in the CMHC catchment area, the CMHC must establish close collaborative arrangement with that hospital in order to develop an effective linkage for the provision of mental health services.

When an eligible veteran can justify that going to a VA facility is a physical hardship, or that the treatment he needs is not available at a VA facility, the VA may purchase that service for the veteran from a CMHC under a fee-for-service arrangement. This takes close collaboration between the CMHC and the VA facility to assure that the veteran's eligibility determination will be made and that the CMHC's proposed treatment plan will be approved for payment.

What It Is. The VA is a Federal agency that administers an extensive array of health care services for veterans. Its programs cover a broad range of Federal benefits for former members and dependents, and beneficiaries of deceased former members of the Armed Forces.

To the veteran, the VA is a comprehensive health service resource provided as a prepaid benefit and available as eligibility is achieved. It represents a catastrophic or last source of care for veterans who do not use the VA services routinely.

What Services Are Covered. The following is a list of VA programs available to the aging veteran:

- General Medical and Surgical (GM&S) Hospitals—144 GM&S hospitals are the primary modality through which the VA provides health care for eligible veterans.
- Extended Hospital Care—This program makes provision for patients who have passed through the acute stage of their illness but who will still require several months of further care (between acute and nursing home care).
- Psychiatric Hospitals—The number of VA psychiatric hospitals has decreased from 41 to 28, as these institutions have been converted to GM&S hospitals. Psychiatric services in GM&S hospitals had only 12 percent of psychiatric beds in 1967; they now have 60 percent.
- Nursing Home Care—This care is provided to eligible veterans in VA, community, and State nursing home facilities.
- VA Nursing Home Care—Nursing home care beds are established adjacent to full-service VA hospitals to accommodate those patients who have little or no potential for placement in other VA extended care or community facilities because of the high level of nursing care required.
- Community Nursing Home Care—This program is intended for veterans whose condition would be improved through placement in a supportive environment of their own community near family and friends. These are proprietary homes which will accept veterans on per diem contract.
- Domiciliary Care—The present 16 domiciliaries provide a protective environment for a large number of younger men who have residual psychiatric disabilities.
- State Veterans Homes—Currently 40 State homes in 31 States provide hospital, nursing home, and domiciliary care. The VA relationship to State homes is based on two grant programs: (1) per diem program which enables VA to help States provide care that meets quality standards; (2) program which provides VA assistance with 65 percent Federal funds to construct new domiciliary and nursing home care facilities, and expansion and remodeling of existing facilities.
- Personal Care Homes—These homes were originally devised as a means of discharging psychiatric patients into the community by providing a basic level of social support in a family setting. This is now the largest VA Extended Care Program with over 22,000 veterans in placement.

- Hospital Based Home Care (HBHC)—Patients with significant residual disability may be helped to remain in their own homes through this program. The patient and his family are provided necessary instruction in routine and nursing procedures under coordinated supervision of a physician, public health nurse, social worker, rehabilitation therapist, dietician, and nursing assistants. At present, there are HBHC teams at 30 hospitals.
- Congregate Housing—This provides a living arrangement for a group of semi-independent veterans who are provided with such services as meals, transportation, assistance with personal care, and laundry. The goal is to enable elderly veterans to remain in the community as long as possible. Its use to date has been mainly for psychiatric patients who need a protected living arrangement with some support.
- Geriatric Day Care—This program is being suggested as an alternative approach for treatment of a selected group of aged veterans with physical and mental disabilities. The program is being perceived as one which would reach the socially isolated and physically handicapped. Objectives would be to provide stimulation and socialization activities in a supervised environment, provide patient and family education, and offer family caretakers relief from stress of continuous care of the patient.

Where To Go for More Information. "VA Installations—Where to go for help." See Appendix G.

Bureau of Community Health Services (BCHS) Programs

Relationship of BCHS Programs to CMHCs. The Bureau of Community Health Services (BCHS) in the Health Services Administration of the U.S. Public Health Service has as its mission the development of the Nation's capacity for delivering adequate basic health services to medically underserved areas and population groups, both rural and urban. The Secretary of the Department of Health, Education, and Welfare has designated a number of areas of the United States as "medically underserved." These areas are characterized by large numbers of people living in poverty, large numbers of people 65 years of age or older, high infant mortality rates, and a shortage of health professionals.

The bureau's organizational units that form the basis of their capacity building effort are the Community Health Centers Program, Migrant Health Program, National Health Service Corps, Appalachian Demonstration Health Program, Health Underserved Rural Areas Program, and Home Health Services Program. These programs provide primary health care to the people who live in the areas which the programs are intended to serve.

Linkage with Mental Health Services. One important element in the bureau's capacity building efforts is the development of the capacity of health center staff to deal with stress and social and psychological problems affecting health. One important element in this capacity is the strengthening of linkages between bureau-supported ambulatory health care projects and other health care resources in order to provide comprehensive health care. One such linkage is with CMHCs. The strengthening of these linkages is the responsibility of an experienced current staff member of the health center or a new staff person employed by the health center with the concurrence of the CMHC. The linkage involves a formal written interagency agreement which is initiated by the BCHS project. The linkage functions of the worker located within the BCHS project include liaison, triage, referral, and followup. One of the most important goals of this linkage is to enhance the capacity of BCHS project staff to recognize and deal with the mental health problems of their patients. The direct mental health services are performed either at the CMHC or the BCHS project. The bureau makes CMHC funds available for the employment of staff in the health center with responsibility for increasing the capacity of the center to deal with the stress, social, and psychological problems, including the strengthening of linkages.

If the BCHS project in your catchment area does not have a linkage with mental health services, your CMHC can explore the possibility of establishing such a linkage by getting in touch with the Director of Alcohol, Drug Abuse, and Mental Health Programs in the Regional Health Administrator's office (see appendix B).

2. Community and Social Support Services Programs

This group of programs covers a wide variety of support services, including income maintenance, social services, housing, transportation, employment, and volunteers.

Supplemental Security Income (SSI) for the Aged, Blind, and Disabled
(Title XVI of the Social Security Act, as amended)

Relationship of SSI to CMHCs. One of the basic concerns about SSI is the proliferation of room-and-board homes since the advent of this program. Such homes are typically unregulated by State and local governments. Conditions with respect to the safety and well-being of residents in some of these homes are deplorable.

Questions have been raised about aftercare programs for patients discharged from State mental hospitals who live in room-and-board homes, and the role of both the hospitals and community mental health programs in encouraging the growth of these homes, made possible with the SSI income-maintenance mechanism. The individual's S.S.I. payments can be used for his or her maintenance in the room-and-board home.

In light of the foregoing observations, CMHCs must be particularly sensitive to the needs of their aftercare patients and the conditions under which they live.

It should be noted that, if a person is receiving SSI, he is eligible for Medicaid and Title XX Social Services in most States. Both are third-party payment programs which CMHCs can make use of to provide and receive reimbursement for costs of treatment.

What It Is. The SSI program is a needs-based income maintenance program. It provides monthly cash payments in accordance with uniform nationwide eligibility requirements to persons with little or no income who are age 65 and over, blind, or disabled. Established by the 1972 amendments to the Social Security Act, the SSI program replaced the programs of old age assistance and aid to the blind established by the original Social Security Act of 1935, and the program to aid the permanently and totally disabled established by the Social Security Amendments of 1950. The former Welfare programs were grant-in-aid programs under which Federal matching funds were made available to the States according to formula specified in the law. The States administered these programs. The SSI legislation, which became effective January 1, 1974, integrated these former public assistance programs into one program which is administered by the Social Security Administration, but the former programs still function in certain circumstances that are noted later. The field offices that handle all other Social Security programs carry on the day-to-day operations of the SSI.

Federal administration of a nationally uniform payment separates out the basic-income security function but does not replace the comprehensive Welfare services programs to meet individual needs which are administered by State and local governments. It has positive values of administrative efficiency and of providing a reliable source of income which permits recipients to manage independently, but it does not replace all of the functions of former programs which provided assistance and other social support services to meet a variety of special needs as well as basic maintenance needs.

How It Works. The basic cash payments for SSI are provided by the Federal Government out of general revenues. The Federal payment is a base to which supplements can be added by the States using their own money.

Mandatory State Supplementation. States that paid higher amounts to former recipients are required by law to supplement the Federal payments through minimum State Supplementation to prevent reduction of income to persons transferred from the old programs to SSI. States were required to adopt minimum State Supplementation programs in order to remain eligible for Medicaid Federal matching funds.

Optional State Supplementation. In addition, States may, but need not, supplement Federal payments through Optional State Supplementation. This optional supplement is intended to help an individual meet needs which are not fully met by the SSI payment. The State determines whether it will make a payment, to whom, and in what amount. States have the option of covering all mandatory supplements under their program of optional supplementation, if their program provides a money amount either equal to or greater than that required by the mandatory supplementation. Since October 1976, States may also make vendor payments to providers of care without having these payments count as "income," provided the payments are based on financial need.

While all States (except Texas, which has a State constitutional barrier) provide Mandatory State Supplementation, provisions for Optional State Supplementation vary considerably among States. Some States provide optional supplementation for all persons qualifying for the basic SSI payment. Some limit payments to certain groups, such as the blind or persons in domiciliary care facilities. Others do not provide such payments at all.

States may choose to have the Social Security Administration administer their Supplementation programs.

Who Is Eligible. Following are the basic eligibility requirements (categorical conditions) for SSI:

Aged—A person must be age 65 or older.

Blind—An individual is considered blind if vision in his better eye is 20/200 or less with use of a correcting lens, or if he suffers from tunnel vision to the extent that his field of vision is not greater than 20 degrees.

Disabled—To be considered disabled, a person must be unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment which has lasted (or is expected to last) for at least 12 consecutive months or which can be expected to result in death.

Income and Resources—Individuals must be in financial need in order to be eligible for SSI, taking into account their income and resources if they have any. The standard SSI payment is made if the individual (or couple) has no countable income. If the individual (or couple) has countable income, a dollar-for-dollar reduction is made against the standard payment. Not all income is counted for SSI purposes. The first $60 in a calendar quarter in earned or unearned income is not counted. Also disregarded is $195 a quarter of earned income plus one-half of any earnings above $195. Generally, individuals are not eligible for payment if they have assets in excess of $1,500 (or $2,500 for a couple), excluding the reasonable value of a home, automobile, household goods, and personal effects and life insurance with a face value of $1,500 or less.

In the SSI program, entitlement factors and income restrictions are complex, and verification of alleged facts is difficult. For example, the amount of SSI payments is conditioned, in part, by the living arrangements of the applicant. SSA must determine whether the applicant lives in an owned home, has an ownership interest, or rents. It must also determine whether the applicant lives alone or with others and, if the latter, the total household expenses and the share paid by the applicant. States specify the living arrangements that must be distinguished for their State supplements. In California, this requires SSA to establish, among other factors, whether an applicant who lives independently does or does not have cooking facilities. Liquid resources, such as cash or financial instruments readily convertible to cash within 20 days, must be identified and valued. Even when eligibility remains constant, the amount of the payment depends upon fluctuating current income and must be recomputed quarterly.

Citizenship and Residence—The individual must reside in the United States and be a citizen or an alien permanently and legally residing in the United States.

Alcoholism and Drug Addiction—Any disabled individual who has been medically determined to be an alcoholic or drug addict must accept appropriate treatment, if available, in an approved facility.

Institutionalization—A maximum of $25 is payable to individuals in public or private institutions who receive more than 50 percent of the cost of their care from Medicaid.

Eligible persons in private institutions whose care is not met from Medicaid funds may receive the standard payment applicable to individuals living in their own households.

Although inmates of public institutions are not eligible for SSI, persons in publicly operated community residences serving no more than 16 persons may be eligible for the standard SSI payment.

Payment may be made directly to the recipient or to a representative payee (including a public or private agency) interested in or concerned with the recipient's welfare, designated by the SSA to receive the payments in his behalf, when such action is deemed appropriate.

How To Apply. It is best to apply in person at any Social Security office. If one has health or transportation problems that prevent this, an application will be mailed out when a person calls or writes the Social Security office.

How Much Are the Payments. Under the SSI program, each eligible aged, blind, or disabled person living in his own household is provided a monthly cash payment from the Federal Government that is sufficient, when added to his countable income, to bring this total monthly income up to a specified level: for an eligible individual, $208.20; and $312.30 for an eligible couple (as of July 1, 1979).

Where To Go for More Information. Any Social Security office.

Food Stamps
(Food Stamp Act of 1977)

Relationship of Food Stamps to CMHCs. CMHC daycare programs furnishing services to the elderly can benefit from the Food Stamp program by qualifying as an operation eligible to accept coupons in payment for meals served any client participating in the Food Stamp program. This can represent substantial savings for CMHCs in the provision of meal services.

What It Is. The Food Stamp program helps persons in low-income households improve their diets by supplementing their food purchasing ability. Low-income families and individuals may receive monthly Food Stamp allotments, varying with income and household size. Elderly and other homebound persons may exchange Food Stamps for home-delivered meals. Elderly and certain disabled persons may use Food Stamps in certain congregate programs.

How It Works. The Federal agency responsible for the Food Stamp program is the Food and Nutrition Service of the Department of Agriculture which carries out the following functions:

- Reviews and approves State operating plans
- Issues food coupons to the State
- Reviews and approves application for participation from retailers, meal services, meal delivery services, drug addiction or alcoholic rehabilitation and treatment programs, and wholesalers
- Issues authorization cards to those entities approved for participation
- Monitors States operation of the Food Stamp program.

At the State level, the Food Stamp program is administered by the State agencies responsible for administering federally aided public assistance (Welfare) programs. The benefits are paid in full with Federal funds. Administrative costs are shared equally by the States and the Federal Government.

Once a State agrees to administer the program, the State agency must submit a plan of operation, indicating the way in which the program will be carried out within the State in every political subdivision. The 1977 legislation sets forth specific Federal standards to be followed by the State for much of the program's administration. The State agency is responsible for the following:

- Certifying applicant households
- Issuance, control, and accountability of coupons
- Developing and maintaining complaint procedures
- Developing and conducting training
- Conducting outreach to potential households
- Monitoring and reporting on the program operation to ensure compliance with the regulations

How To Qualify for Provider Status. To qualify for authorization to accept Food Stamps, the organization operating a communal dining service for the elderly must be either publicly owned and operated, or must be a private, nonprofit organization. A CMHC that wants to qualify must fill out Form FNS-252-2, Meal Service Application for Authorization to Participate in the Food Stamp Program. This form can be obtained from a Department of Agriculture field office. A field office representative will visit the CMHC to be sure the center is a "qualified" operation and to assist in completing the application. If the CMHC is approved, an authorization card is issued to the center. Food Stamps are then collected for meals at the time meals are served or at the end of a specified period, not to exceed 1 month, for the meals served during the period.

Who Is Eligible. Program eligibility is based among other things, on the resources and income of household members.

A household may consist of a person living alone or any group of people who buy and prepare food together. Roomers and boarders may qualify as separate households. Full- and part-time students are eligible. There is no longer a requirement for a cooking facility in the household.

Categorical eligibility which was available to Welfare and certain Supplemental Security Income (SSI) recipients has been ended. All recipients must meet certain requirements: (1) a fairly low income; (2) few resources or assets; (3) work registration up to age 59. (To check on other specific requirements, call the Hot Line described in last paragraph.)

Income is measured on a monthly basis to include regularly received money which is "reasonably certain" to be coming in to the recipient during the month. Excluded from income is money earned by a student under 18, all lump sum payments such as tax refunds, all loans (except a portion of education loans) whether from commercial outfits or personal friends, and any in-kind benefits.

From the monthly gross income, four possible deductions can be subtracted to determine net income for eligibility. These deductions have been nationally standardized by the 1977 legislation and amendments to that legislation. They include the following:

- Work deduction—20 percent of pay from a job, work training program, or workfare program (where person works off his Welfare grant)
- Standard deduction—$75 per household. Note: The standard deduction may change on July 1, 1980, depending on what happens to the cost of living
- Dependent care deduction—expenses to care for a child or other dependent in order to work

- Excess medical deduction—that portion of medical expense in excess of $35 per month incurred by any household member who is 60 years of age or over or who receives SSI or Social Security disability benefits
- Shelter deduction—shelter expenses (rent or mortgage plus utilities and telephone) that exceed 50 percent of income after the other deductions have been subtracted.

Note that the dependent care and shelter deduction, alone or combined, cannot exceed $90. This $90 figure may change on July 1, 1980, depending on what happens to the cost of living. Households containing a member who is 60 years or older or who receives SSI or Title II disability payments are subject to the $90 cap for dependent care but not for shelter expense.

All applicants for Food Stamps must meet the following net income scale after all possible deductions are made:

Household size	*Maximum allowable net income*
1	$306
2	$403
3	$500
4	$596
5	$693
6	$790
7	$886
8	$983
Each additional member	+ $97

The above figures, which are related to the official poverty levels, will be updated every July 1, depending on the cost of living.

Resources which may be retained and still qualify for Food Stamps:

- $3,000 for all households with two or more persons which include at least one member age 60 or over
- $1,750 for all other households.

Under the Act, assets do not include: (1) the household's home and surrounding property; (2) personal belongings and household goods; (3) rental property or property upon which a house is going to be built; (4) property and equipment used for self-improvement; (5) the cash value of insurance policies, pension funds, and other resources whose cash value is not immediately available to the household. Also exempted are vehicles, inaccessible resources, resources excluded by law, and resources of nonhousehold members.

To be eligible for food stamps, every member of the family age 18 through 59 must register for work (except adults responsible for the care of young children or invalids, or anyone already working at least 30 hours a week). The law requires the eligible person to go out on job interviews and accept any offer, within reasonable traveling distance, consistent with his physical and mental fitness.

How To Apply. Applications for Food Stamps may be made at any county (local) public Welfare Department.

Once an applicant gets in touch with the office responsible for issuing Food Stamps, he has an absolute right to file an application that day, either by phone or mail. He must be furnished with a simple, understandable, uniform application form. If the office serves at least 100 households who speak another language or a smaller community in which the majority of households speak the same non-English language, the applicant must be met at the office by an interpreter or bilingual staff member.

Most households are required to have a face-to-face interview at the office. However, if age or incapacity prevent it, the interview must be conducted by phone or at the home of the applicant. The face-to-face interview may be waived if transportation problems, illness, severe weather, or work hours prevent the applicant from coming to the office. From the date a proper application is filed, the local office has 30 days to process the application. Expedited service is available to households in immediate need.

What Is the Food Stamp Allotment. The actual amount of Food Stamps issued depends on the net income of the family or individual, and there is a maximum on this amount, depending on household size. This amount ranges from $63 in Food Stamps for one person to $376 in Food Stamps for a household of eight persons.

Under the new law, recipients of Food Stamps no longer pay for them. Only the poorest households receive the coupon value of what is called the Thrifty Food Plan (TFP) which is the Department of Agriculture's standard of measurement for a minimally adequate diet. All other households receive Food Stamps reduced from the TFP by 30 percent of the household's net income as defined by the law.

How Food Stamps May Be Used. The Food Stamps may be used in participating retail stores to buy any food for human consumption, and garden seeds and plants to produce food for consumption by eligible households. Food Stamps may be used by elderly persons who cannot prepare their own meals or pay for meals delivered to them in their homes by authorized, nonprofit, meal-delivery services. Elderly persons may also use Food Stamps to purchase meals in establishments providing communal dining for the elderly. Drug addicts and alcoholics who are participating in approved rehabilitation programs may use Food Stamps to purchase meals.

Where To Go for More Information. The Food and Nutrition Service of the U.S. Department of Agriculture has a network of field offices throughout the country. The field office that services your area should be listed in the local telephone directory under U.S. Government, Agriculture, Department of. In addition, each State agency operates a toll-free hotline service which provides participants and applicants with program information.

Social Services for Low-Income and Public-Assistance Recipients
(Title XX of the Social Security Act, as amended)

Relationship of Title XX to CMHCs. Funds available under this program can be used to help defray the costs of mental health services for the aged who are, or who can qualify as, recipients or beneficiaries of the Title XX program. For these funds to be made available, either the State Department of Mental Health or an individual CMHC must enter into a formal agreement or contract with the State Title XX agency.

What It Is. Title XX is a Federal program of formula grants to States for the purpose of enabling each State to provide social services to public-assistance recipients and other low-income persons. The services are directed toward the following goals:

1. Achieving or maintaining economic self-support
2. Encouraging self-sufficiency
3. Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families
4. Preventing or reducing inappropriate institutional care by providing for community-based, home-based, or other less intensive forms of care
5. Securing referral or admission for institutional care, when other forms of care are not appropriate, or providing services to individuals in institutions.

Each State has a single designated agency responsible for administering the Title XX social services program or supervising local agencies which administer the program. The State agency must prepare a Comprehensive Annual Services Program Plan (CASP) which is subject to citizen review and approval by the Governor. The final plan is also subject to Federal Government approval as to procedures and compliance with regulations (Federal) but not as to selection of services or areas of the State where the services are available. In the CASP, the State must describe the steps taken to assure that the needs of all residents of, and all geographic areas in, the State are taken into account in the development of the services plan. The State must also describe how the planning and provision of services under the program will be coordinated with and use other human services programs within the State. Community mental health programs have an opportunity to influence both the direction and detail of the State Title XX plan through providing evidence of mental health needs and through the coordination requirement.

A CMHC should maintain contact with the State Mental Health Department and/or the State Title XX agency to determine how resources are allocated to mental health services and what services are included in the State plan that can be provided by mental health programs. There is a "cap" on money available from Title XX, and representatives of all kinds of services compete for inclusion in the CASP.

How It Works. Federal funds are matched with State funds in a ratio of 75 Federal to 25 State for all services provided by a State under the Title XX program (except family-planning services which are matched at a ratio of 90:10).

Federal matching is subject to a cap in the form of an annual appropriation passed by the Congress ($2.9 billion in FY 1979). Each State receives a fixed allotment, allocated on the basis of the ratio of the State's population to the total U.S. population which is that State's ceiling from Federal funds. A State may choose to put additional unmatched State funds into the program.

At least 50 percent of Title XX funds received by the State must be spent on behalf of the most disadvantaged category of clients, i.e., persons receiving or who are eligible for Supplemental Security Income, Aid to Families with Dependent Children, and those who if they applied could qualify for those two programs or the State's Medicaid program.

Who Can Provide the Mental Health Services. State requirements and procedures regarding provider participation vary from State to State. Nonetheless, all CMHCs must be concerned with meeting certain general prerequisites to participation under Title XX: (1) administrative requirements and (2) accreditation and licensure standards established or adopted by the State.

The most important administrative requirement is that a CMHC must negotiate a formal agreement with the Title XX agency in order to be a provider. In a particular State, this "purchase of service agreement" may be with the State Department of Mental Health. In such a case, individual centers would still be bound to the agreement by subcontracts which would have to meet the same requirements.

With respect to provider standards, Title XX itself is sparse. It would be well to determine whether the State has established licensure requirements for CMHCs which must be met in order to be eligible for Title XX funds.

Who Is Eligible for Service. The following three major groups of individuals are eligible for services:

Income maintenance status eligibles—Recipients of Supplemental Security Income (SSI) or State Supplemental payments, or Aid to Families with Dependent Children (AFDC).

Income status eligibles—Low-income individuals and families whose gross monthly income does not exceed 115 percent (or at State option, some lower percentage) of the median income for the same-sized family in the State. Fees must be required of persons whose income exceeds 80 percent of the State median income and may be required at State option from persons with lower incomes.

Persons served without regard to income—States may also serve individuals without regard to income for certain services: family planning; information and referral; and services to prevent or remedy neglect, abuse, or exploitation of children and adults. States may charge a fee for these services. If they do, some income information would be obtained on these individuals.

What Services Are Included in a Title XX Program. Each State determines the social services that will be included in the State Title XX plan. Title XX does not define them but does indicate what will *not* be reimbursed with Federal funds, e.g., educational services that are generally available, land acquisition or services provided by institutions to their inmates. There are other restrictions with respect to medical care, room and board, daycare services, "in kind" matching, and donated funds.

The State must describe in its plan each discrete service to be covered, the method of delivery, and the categories of individuals in each geographic area to whom each service will be provided. Among the services to be provided in each geographic area, at least three services must be available for SSI recipients, and at least one service must be directed at each of the Title XX goals.

Examples of programs directly benefiting the elderly that are being provided under Title XX include service centers, homemakers, housekeepers, protective services, transportation, escort services, and legal services.

There is little known about coverage of mental health services on a nationwide basis. Therefore, review of your own State plan is essential to determine what services that can be provided by your CMHC are specifically covered in the plan. When the annual Title XX plan is being prepared, there is an opportunity for the centers to influence the scope of services included in the plan.

What Are the Reimbursement Rates. States establish their own rates of reimbursement for community mental health services. Methods by which rates are to be determined are also left to the States. When services are purchased from other public agencies, rates shall be established in accordance with cost principles of Chapter 45, Code of Federal Regulations, Part 74, Appendix C. When services are purchased from private agencies, rates may be established on the basis of negotiation, using any reasonable method, including the Principles for Determining Costs suggested in Appendix F of the aforementioned document.

The "purchase of service agreement" must state the specific rate or the method to be used in determining the rate.

Where To Go for More Information. A *Title XX Handbook for Alcohol, Drug Abuse, and Mental Health Treatment Programs* was issued by the Alcohol, Drug Abuse, and Mental Health Administration DHEW, in 1978. It provides excellent guidance to State and local agencies regarding all aspects of the Title XX program. A copy can be obtained from the National Institute of Mental Health, 5600 Fishers Lane, Rockville, Maryland 20857. It is DHEW Publication No. (ADM) 78739.

State Title XX Agency. See Appendix F.

State Mental Health Authority. See Appendix C.

Housing Programs

Relationship of Housing Programs to CMHCs. The availability of adequate and affordable housing for different groups of the elderly, including the mentally disabled elderly, is essential, if the CMHCs are to provide alternatives to institutional care. All the elderly should have access to a variety of housing, ranging from independent living to institutionalization, including such semi-independent living arrangements as sheltered and congregate housing, domiciliary care, and foster care. Further, suitable arrangements should be available in the community for elders with low and moderate, fixed incomes.

Information about Housing Programs. A Guide to Federal Housing Programs for the Mentally Disabled was issued by the National Institute of Mental Health in 1978. It is designed to provide the reader with specific information concerning the provisions of various Federal housing programs and their potential for assisting in the development of residential options for persons, including elderly persons, disabled by mental health problems. It is an excellent resource for learning about the different Federal housing programs, including (but not limited to):

- Lower income rental assistance program under Section 8 of the Housing Act of 1937, as amended, which provides rent subsidies for low income persons and families to help them afford decent housing in the private market.
- Housing for the elderly and handicapped under Section 202 of the Housing Act of 1959, as amended under which the Department of Housing and Urban Development (HUD) issues long-term loans and Section 8 subsidies to eligible, private, nonprofit sponsors to enable them to finance rental or cooperative housing facilities for elderly or handicapped persons.
- Mortgage insurance on rental housing for the elderly (under Section 231 of the National Housing Act of 1934, as amended) which can be used optionally within the Section 8 program, to assure a supply of market rental housing units suited to the needs of the elderly.
- Rural rental housing loans (under Section 515 of the Housing Act of 1949, as amended) under which the Farmers Home Administration of the Department of Agriculture makes insured loans to construct, improve, or repair rental or cooperative housing in rural areas for low-income persons, including senior citizens age 62 and over.

Congregate housing for the elderly or handicapped is a new use of the Section 515 Program. The Farmers Home Administration (FmHA) and the Administration on Aging (AoA) have jointly launched a demonstration program to establish congregate housing for the rural elderly. While FmHA is supporting the cost of construction (up to $1 million for each of 10 projects), AoA is providing funds in the amount of up to $850,000 for each year of the 3-year demonstration period to each project to support the services components—which at a minimum must include: meals, housekeeping, and personal care when needed, transportation, and social and recreational activities. Loans for congregate housing projects not involved in the FmHA/AoA demonstration program are available from the Farmers Home Administration both during and after the demonstration period.

The guide links specific Federal funding options to a range of alternative community-living arrangements, showing their direct relevance for the establishment and support of different residential options for the mentally ill. The guide lays out specific strategies which the State and CMHCs can apply to the process of securing funds and developing residential programs. It also describes other sources of Federal funding which can be used to supplement clients in various living arrangements; the role of the State mental health authority; steps which should be taken to assure involvement in the local housing planning process; strategies for obtaining Section 8 subsidies; and considerations regarding construction and barriers presented by zoning restrictions.

Specific examples are provided to demonstrate how mental health agencies have effectively used different residential arrangements for their clients and have successfully negotiated agreements with HUD, State, and local housing authorities regarding various kinds of living arrangements for the mentally ill.

The Appendixes include directories of: HUD Area and Regional Offices and the names of the HUD Elderly and Handicapped Housing Coordinators; Department of State Housing Finance Agencies; State Offices of Community Affairs; and a list of relevant projects cited in the guide with names, addresses, and telephone numbers.

One of the most important things learned from this guide is that Federal housing programs have many complex provisions and qualifications and that it takes a tremendous amount of "know-how" and collaborative persistence to develop and use these housing resources effectively.

The reader can obtain a copy of *A Guide to Federal Housing Programs for the Mentally Disabled* from the National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20857. It is DHEW Publication No. (ADM)78674.

A Note About New Housing Legislation. New congregate housing services are now available to elderly and handicapped residents of public housing projects as a result of legislation enacted as part of the Housing and Community Development Amendments of 1978. Title IV of this legislation provides for congregate housing services to be provided in public housing and section 202 nonprofit housing projects.

Elderly individuals either permanently or temporarily disabled are eligible for the services which are designed to prevent unnecessary institutionalization.

Congregate services assisted under the program must include congregate meals and may also include housekeeping aid, personal assistance, and other services essential for maintaining independent living.

Transportation Programs

Relationship of Transportation Programs to CMHCs. Transportation is the facilitating link between the elderly person in need and the service required to meet that need. The mentally disabled elderly patient in need of treatment must be able to get to the mental health center for that treatment, or he is in deep trouble.

Lack of transportation is strongly related to age and income. Many older persons, due to disabilities and limited income, cannot rely on private automobiles for their transportation. The same conditions may limit their use of mass transit systems. Or there may be no public transportation available in the areas where they live.

The CMHC must be sensitive to the problems of transportation which confront older individuals in the catchment area where the center is located. The center needs to address these problems at two different levels:

1. Find community resources that can help individual patients get to and from the CMHC, if they need that help. For example, cooperative arrangements can be worked out with the area agency on aging to have their transportation service include the center.
2. Actively support the efforts being made in their community to help meet the overall transportation needs of their older pop-

ulation. Many communities and civic organizations offer or are experimenting with different forms of assistance to help meet the transportation needs of older persons.

Department of Transportation (DOT). The Urban Mass Transportation Administration (UMTA) in the Department of Transportation administers a program of research development grants to test innovative approaches to transportation problems and funding for capital assistance, the acquisition of vehicles and other needed equipment.

UMTA has conducted a variety of projects that have benefited the elderly; for example, specially equipped vehicles capable of handling handicapped persons, demand responsive (dial-a-bus) systems, and transit systems geared to needs of neighborhoods. Three major programs that help meet the transportation needs of older people are the following:

- Capital assistance grants for use by private nonprofit groups, Urban Mass Transit Act of 1964, as amended, Section 16(B)(2)—Provides money for capital assistance grants to private, nonprofit corporations and associations to help them provide transportation services for the elderly and handicapped in urban areas.
- Reduced fares, Urban Mass Transit Act of 1964, as amended—Requires that any public transit system receiving funds under Section 5 of the UMT act for either capital or operating expenses from UMTA must charge elderly and handicapped individuals no more than half fare during off-peak hours.
- Rural and Small Urban Transit Program Section 18 of the Surface Transportation Assistance Act of 1978—Funds are available by way of a formula-grant program to States to support public transportation in nonurbanized areas (rural and small urban areas with populations under 50,000). The Section 18 program provides funds for both capital and operating assistance to State agencies, nonprofit organizations, and operators of public transportation services. This program is administered jointly by the Federal Highway Administration and UMTA of DOT.

Administration on Aging (AoA) Under Title III of the Older Americans Act, which authorizes support for State and community programs, transportation is recognized as an important component of comprehensive and coordinated services to the elderly. The State agency on aging can identify potential sources of funding for transportation, provide advice on how best to plan for and implement a project, and coordinate efforts with other agencies and organizations that might be involved in planning and supporting transportation projects. Under certain limited circumstances, the State agency on aging can provide direct project funding.

DOT and AoA, under a joint working agreement, have pledged mutual cooperation and coordination in helping to meet the transportation needs of older people in urban areas.

Employment and Volunteerism

Relationship of Employment and Volunteerism to CMHCs. CMHCs can make efficient use of employees paid by the Comprehensive Employment and Training Act (CETA) and volunteers for manning outreach, telephone reassurance, companionship, and other social supports that make mental health services more effective.

Department of Labor. Comprehensive Employment and Training Act (CETA)—The purpose of this legislation is to provide job training and employment opportunities for economically disadvantaged, unemployed, and underemployed persons. The act is administered by the Department of Labor.

All States and cities, counties, and combinations of local units of government with populations of 100,000 or more receive direct Federal grants under CETA to design and administer comprehensive employment and training programs that serve the needs of their area. These 465 State and local units, called "prime sponsors," operate projects themselves or contract with other groups to provide services. Under the 1978 legislation extending CETA for 4 years, numerous private nonprofit organizations, including those serving senior citizens, will also be able to participate in employment and training programs by entering into subcontracts with local prime sponsors. Such subcontractual arrangements may involve the provision of training or employment for eligible seniors, or the placement of CETA employees in special projects benefiting senior citizens. The CMHC or area agency on aging can take advantage of this provision.

For additional information about CETA, the reader should get in touch with the agency designated to run the CETA program in his area. It may be called Manpower Office, the Human Development Department, or the Employment and Training Administration. The mayor or county commissioner's office or the State or area agency on aging will have this information. There also are 10 regional offices of the Department of Labor in the same cities as DHHS regional offices.

Senior Community Service Employment Program (SCSE)—Authorized under the new Title V (formerly Title IX) of the Older Americans Act, this program is administered by the Department of Labor. Its purpose is to provide useful part-time employment opportunities in community service activities for low-income persons who are 55 or older and who have poor employment prospects. Public and private nonprofit agencies are eligible to receive project grants under this program. Participants work in a variety of activities, including daycare centers, hospitals, facilities for the handicapped, senior citizen centers, and nutrition programs.

ACTION is the Federal volunteer agency which is responsible for the following volunteer programs that seem most relevant to CMHCs:

Foster Grandparent Program—This program provides part-time volunteer service opportunities to low-income men and women, age 60 and over, in good health, to provide love and attention to physically, emotionally, and mentally handicapped children in institutions and in private settings.

Project grants to support this program are made only to public and nonprofit private agencies or organizations, including State and local governments. At least 10 percent of total project costs must be met by the applicant.

Volunteers receive 40 hours of orientation, are supervised by childcare teams in their assigned agencies, and attend inservice training sessions. They receive a weekly stipend, transportation allowance, hot meals while in service, accident and liability insurance, and annual physical examinations.

Retired Senior Volunteer Program (RSVP)—The objective of this program is to establish a recognized role in the community and a meaningful life in retirement for persons aged 60 and over, by developing a variety of community volunteer service opportunities. Through this program, retired or semi-retired men and women serve in agencies, organizations, and institutions designated as Volunteer Stations. These include courts, schools, libraries, daycare centers, hospitals, and nursing homes.

Project grants may be made to established community service organizations (public or private nonprofit) to assist in development or operation, or both, of locally organized senior volunteer projects. A local program also arranges for transportation for RSVP volunteers, as needed.

The non-Federal support during the first year must be at least 10 percent. Grantees are expected to increase local share of project cost by 10 percent each year and to assume a minimum of 30 percent financial responsibility at the beginning of the third year and each year thereafter.

Volunteers may be reimbursed, upon receipt, for transportation to and from their assignment, meals, and other out-of-pocket expenses. After placement, they receive inservice instruction and supervision.

Senior Companion Program (SCP)—This program, patterned after the Foster Grandparent Program, provides opportunities for low-income men and women age 60 and over to serve adults with special needs, especially the elderly, in their own homes, in nursing homes, or other institutions. It was authorized by the Older Americans Comprehensive Services Amendments of 1973 as a complement to other community programs and is intended to help fill critical gaps in the provision of services to persons receiving nursing care and to those with developmental disabilities.

Project grants are made only to public or nonprofit private agencies or State and local government agencies. Other provisions of the program are similar to those for the Foster Grandparent Program.

Volunteers in Service to America (VISTA)—This program is a national corps of men and women of all ages with particular talents and experience who work for a minimum of 1 year in impoverished urban and rural areas. They may live and work with migrant families, on Indian reservations, in institutions for the mentally handicapped, and in a variety of other settings. They may help people tackle problems in education, daycare, drug abuse, corrections, health, legal aid, and city planning.

Sponsors applying for VISTA Volunteers must be public or nonprofit organizations, including State and local governments. The project in which they propose to use volunteers must be related to poverty.

Volunteers receive preservice orientation and inservice training as needed. Service benefits include a subsistence allowance sufficient for the community where the volunteer serves, necessary health benefits, and a $900 stipend after one year of service.

For more information about the volunteer program, the reader should get in touch with national headquarters. The current address and telephone number are: ACTION, 806 Connecticut Ave., N.W., Washington, D.C. 20525. (202) 254-7376.

3. Aging Programs

Every individual involved in the provision of services to the elderly anywhere in this country should have a working knowledge of the Older Americans Act. Under this Federal legislation, each State has an established Office on Aging, and the States have, in turn, designated area agencies on aging to serve older persons in specific communities. These agencies constitute a network to carry out the objectives of the Older Americans Act and the programs authorized by this legislation. These programs cut across all areas of concern to older people, including health, housing, transportation, institutional care, income, employment, age discrimination, and retirement.

One of the act's stated objectives is to achieve: "The best possible physical and mental health which science can make available and without regard to economic status." This objective is to be achieved through activities of area agencies on aging that are supported under the Older Americans Act. These agencies and CMHCs have in common the responsibility for coordination and linkages with existing community services for the elderly.

This section of the guide includes a brief description of the Older Americans Act, covering the highlights of this legislation which has been amended seven times in the period between 1965 and 1978. It includes a description of State and Community Programs on Aging (Title III). Information is also provided about Training Programs for Personnel in the Field of Aging (Title IV, Part A, Section 404) and Demonstration Projects (Title IV, Part C, Section 421).

The description of Title III programs is presented in terms of the broad service which the local area agencies on aging are authorized to coordinate and support. This is in contrast to the description of programs, like Medicare and Medicaid, which focus on eligibility and benefits for the individual.

The information on training and demonstration projects is primarily in terms of resources available to agencies that provide services to the elderly, rather than in terms of benefits directly available to the elderly person.

The program of the Community Service Employment for Older Americans, Title V (formerly Title IX) of the Older Americans Act, as amended, is listed in the social supports part of the guide with employment programs.

The Older Americans Act—Highlights

The Older Americans Act of 1965 established a focal and advocacy point for the aging within the Federal Government. The act created an Administration on Aging within the Department of Health, Education, and Welfare and put into law a Declaration of Objectives for Older Americans which cuts across all areas of concern to the Nation's older citizens. Title I, Section 101, of the Older Americans Act states:

> The Congress hereby finds and declares that, in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our Nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States and of the several States and their political subdivisions to assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives:
>
> (1) An adequate income in retirement in accordance with the American standard of living.
>
> (2) The best possible physical and mental health which science can make available and without regard to economic status.
>
> (3) Suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.
>
> (4) Full restorative services for those who require institutional care.
>
> (5) Opportunity for employment with no discriminatory personnel practices because of age.
>
> (6) Retirement in health, honor, dignity—after years of contribution to the economy.
>
> (7) Pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities.
>
> (8) Efficient community services, including access to low-cost transportation, which provides a choice in supported living arrangements and social assistance in a coordinated manner and which are readily available when needed.
>
> (9) Immediate benefit from proven research knowledge which can sustain and improve health and happiness.
>
> (10) Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives.

In addition to the Declaration of Objectives of the Older Americans Act embodied in Section 101, the 1973 Amendments stated their objectives as follows:

> SEC. 101. The Congress finds that millions of older citizens in this nation are suffering unnecessary harm from the lack of adequate services. It is therefore the purpose of this Act, in support of the objectives of the Older Americans Act of 1965, to—
>
> (1) make available comprehensive programs which include a full range of health, education, and social services to our older citizens who need them.

(2) give full and special consideration to older citizens with special needs in planning such programs, and, pending the availability of such programs for all older citizens, give priority to the elderly with the greatest economic and social need,

(3) provide comprehensive programs which will assure the coordinated delivery of a full range of essential services to our older citizens, and, where applicable, also furnish meaningful employment opportunities for many individuals, including older persons, young persons, and volunteers from the community, and

(4) insure that the planning and operation of such programs will be undertaken as a partnership of older citizens, community agencies, and State and local governments, with appropriate assistance from the Federal Government.

As first enacted, the act authorized funding under Title III for the creation of a State agency on aging in each State. Title III also provided funds for each State agency to initiate local community projects to provide social services to older persons.

Title IV of the Act provided for grants and contracts to public and private nonprofit agencies, organizations, institutions, and individuals to study and evaluate the status of the elderly and to develop approaches for improving conditions for them and for improving the coordination of community services.

Under Title V, provision was made for grants or contracts to public and private nonprofit agencies, organizations, and institutions for training and the development of curricula designed to aid persons employed in or preparing for employment in programs related to the act.

In 1972, a new Title VII was enacted which authorized funds for local community projects to provide nutrition services to the elderly. The projects were designed to provide persons age 60 and older with at least one hot nutritious meal five or more days a week. Emphasis in the project was placed on serving older persons with the greatest economic need and on reducing the isolation of old age.

The 1973 amendments revised the Title III State grant programs in order to provide a better organization at State and local levels. The State agency was directed to divide the entire State into planning and service areas, determine for which areas an area plan would be developed, and designate an area agency on aging to develop and administer the plan in each area.

Local area agencies on aging were charged, under the act, with a continuing process of planning for services for older people and with conducting an action program for the delivery of needed services, pooling untapped resources to strengthen or initiate them, and inaugurating new ones. Area agencies on aging subcontract with local agencies to deliver direct services. With the exception of information, referral, and coordination, State and area agencies on aging may provide direct services only if they would be unavailable otherwise.

Under the 1973 amendments, the Areawide Model Project Program, which has provided experience in coordinating community services, was superseded by a new model projects program to provide grants or contracts for demonstration to "promote the well-being of older persons."

In 1973, Title IV and Title V of the original Act were combined in a single Title IV. The 1973 amendments added a new Title V which authorized the Commissioner on Aging to make grants directly to local community agencies to pay part of the cost of the acquisition, renovation, alteration, or initial staffing of facilities for use as multipurpose senior centers.

The 1975 amendments specified four priority services to be provided under State plans: transportation, home services, legal services, and residential repair renovations.

The 1978 amendments to the Older Americans Act represent another evolutionary step in the process of establishing in each planning and service area on aging a basic capacity to respond to the needs of older persons. They consolidated, under an amended Title III, the social services, nutrition, and multipurpose senior center programs authorized before under Titles III, VII, and V. The 1978 amendments contain renewed emphasis on the concept of a single focal point for service delivery within each community and expect that each area agency on aging, in carrying out its plan, will assure that nutrition services and social services are fully integrated.

The Administration on Aging has prepared a composite of the Older Americans Act, as amended in 1978, in which the titles of the reenacted legislation appear in the following format:

- Title I—Declaration of Objectives: Definitions
- Title II—Administration on Aging
- Title III—Grants for State and Community Programs on Aging
  - Part A—General Provisions
  - Part B—Social Services
  - Part C—Nutrition Services
    - Subpart 1—Congregate Nutrition Services
    - Subpart 2—Home Delivered Nutrition Services
- Title IV—Training, Research, and Discretionary Projects and Programs
  - Part A—Training
  - Part B—Research and Development Projects

Part C—Discretionary Projects and Programs
Demonstration Projects
Special Projects in Comprehensive Long-Term Care
Special Demonstration Projects on Legal Services for Older Americans
National Impact Demonstrations
Utility and Home Heating Cost Demonstration Projects
Part D—Mortgage Insurance and Interest Grants for Multipurpose Senior Centers
Part E—Multidisciplinary Centers of Gerontology
Part F—Authorization of Appropriations
Title V—Community Service Employment for Older Americans
Title VI—Grants for Indian Tribes

The 1978 amendments to the Older Americans Act are in the process of being implemented. Further information about current program provisions and how they are being interpreted may be obtained by getting in touch with the Administration on Aging (AoA) Regional Director in the DHHS Regional Office (see appendix B).

State and Community Programs on Aging (Title III of the Older Americans Act, as amended)

Relationship of State and Community Programs on Aging to CMHCs. The mission of the programs authorized by Title III of the Older Americans Act is to develop and strengthen community systems of coordinated and comprehensive services which enable older persons to live in dignity and independence as long as possible. To achieve this objective, these programs strive to encourage a broad continuum of services which will assure that the appropriate level of care is available to all older persons in their communities, depending on their particular needs. These range from the stimulating mental and physical activities essential to the well elderly, through supportive independent living arrangements, to an intensive level of service required by the frail and seriously disabled.

CMHCs and State and community aging programs have mutual need of each other with respect to services for the elderly. CMHC services are an essential component of the coordinated service network which the aging programs seek to develop and sustain. CMHC patients need to have all of the services of the aging programs accessible and available to them.

The CMHC can use its influence with the area agency on aging to give high priority to the kinds of services that are most helpful to older persons with mental problems. It can also enter into a working agreement with the area agency to assure that appropriate mental health services are available to older persons.

1978 Changes in Title III of the Older Americans Act. The 1978 amendments to the Older Americans Act authorized a new comprehensive Title III, consolidating former Title VII (Nutrition), Title V (Multipurpose Senior Centers), and Title III (Social Services), and providing separate authorizations for social services, congregate meals, and home-delivered meals. The Commissioner on Aging has the authority to waive consolidation requirements for a 2-year period, when compliance would reduce or jeopardize the quality of services, provided progress is being made toward consolidation.

State and Area Agencies on Aging. Title III, Part A (General Provisions) provides a program structure which is designed to establish and support State and local area agencies on aging. These agencies use funds authorized by the Older Americans Act to support and coordinate comprehensive services for persons age 60 and over.

Each State is required to have a State agency on aging with special obligations and responsibilities, including the designation of local planning and service areas and the establishment of local area agencies on aging. Both State and area agencies on aging serve as advocates of the elderly, develop three-year plans for a system of coordinated and comprehensive services for the elderly, with annual adjustments as needed, and assurance that preference in providing services will be given to older persons with the greatest economic or social needs. In addition, the State agency on aging must carry out the following responsibilities:

1. Insure that State plans are based on area plans developed by the area agencies on aging within the State.
2. Develop a formula for intrastate distribution of formula grant funds and submit this formula to the Commissioner on Aging for review and comment.
3. Provide, on request, a hearing for any general purpose local government, with a population of 100,000 persons or more, which seeks designation as a planning and service area.
4. Provide a hearing for any agency submitting an area plan, or to any provider or prospective provider of services, which so requests.

5. Spend an additional 5 percent above amount spent in FY 1978 of its Title III allotment for services to older persons living in rural areas.

Area agencies on aging are required to:

1. Designate, whenever possible, a focal point for comprehensive service delivery within each community as a means of promoting coordination of services.
2. Develop and publish methods by which priority of services is determined.
3. Use Title III funds only to support services covered by an approved area plan.

Annual appropriations are used to make grants to States. Grant amounts are determined according to the ratio of the State's population age 60 and older to the total U.S. population age 60 and older.

Regarding support for State and area administration, Title III guarantees States at least $300,000 per year and provides that not more than 8.5 percent of each State's allotments for Title III social and nutrition services may be used for area agency administration. Federal funds may be used to pay up to 75 percent of State or area agency administrative costs. Title III social and nutrition services are eligible for up to 90 percent Federal support in FYs 1979 and 1980 and up to 85 percent in FY 1981. The non-Federal share may be cash or in kind.

Social Services. Title III, Part B (Social Services), provides for making grants to States under approved State plans for any of the following social services:

1. Health, continuing education, welfare, informational, recreational, homemaker, counseling, or referral services
2. Transportation services to facilitate access to social services and/or nutrition services
3. Services designed to encourage and assist older individuals to use facilities and services available to them
4. Services designed to assist older individuals to obtain adequate housing, including residential repair and renovation projects to enable older individuals to maintain their homes or to adapt homes to meet needs of older individuals suffering from physical disabilities
5. Services designed to assist older individuals in avoiding institutionalization, including preinstitution evaluation and

screening and home health services, homemaker services, shopping services, escort services, reader services, letterwriting services, and other similar services designed to assist such individuals to continue living independently in a home environment

6. Services designed to provide legal services and other counseling services and assistance, including tax counseling and assistance and financial counseling to older individuals
7. Services designed to enable older individuals to attain and maintain physical and mental well-being through programs of regular physical activity and exercise
8. Services designed to provide health screening to detect or prevent illness, or both, that occur most frequently in older individuals
9. Services designed to provide preretirement and second-career counseling for older individuals
10. Services of an ombudsman at the State level to receive, investigate, and act on complaints by older individuals who are residents of long-term care facilities and to advocate the well-being of such individuals
11. Services designed to meet the unique needs of older individuals who are disabled
12. Any other services determined to be necessary for the general welfare of older individuals

Each area agency is required to spend at least 50 percent of its Title III Social Services allocation on in-home services (homemaker and home health aides, visiting and telephone reassurance, and chore maintenance), access services (transportation, outreach, information and referral), and legal services. No specific amount must be spent on any one of these three service areas; however, some funds must be spent in each category unless the area agency can demonstrate that the needs addressed by one or more of the three priority service categories are being met adequately using other resources.

Legal services can be provided under Title III through a Legal Services Corporation project or another legal services provider agreeing to coordinate its services with a Legal Services Corporation project in the area, in order to concentrate the use of funds on older persons with the greatest need who are not eligible for legal assistance under the Legal Services Corporation Act.

At least one percent, or $20,000, whichever is greater, of a State's Title III Social Services allotment must be spent to support a statewide long-term care ombudsman program. State agencies may either operate the ombudsman program themselves or delegate the activities to another agency by contract or other arrangements.

Multipurpose senior centers serve as focal points in communities for the delivery of a range of health, nutritional, social and recreational services designed primarily for older persons.

States will be permitted to use Title III Social Services funds for limited construction of multipurpose senior centers in areas where no suitable facility exists. Previously, only acquisition, renovation, and alteration of existing facilities were allowed. States will also be able to use Title III Social Services funds for personnel and operating costs of senior centers.

Nutrition Services. The National Nutrition Program for Older Americans, administered by the Administration on Aging, is designed to provide inexpensive, nutritionally sound meals to older Americans, particularly those with greatest economic or social need.

A Nutrition Program project must serve persons 60 years of age and over and their spouses of any age, with an emphasis on serving those with greatest economic or social need. Meal sites are required to be located in urban areas that have heavy concentrations of target-group older Americans and in rural areas that have high proportions of eligible older persons.

No one may be turned away from a meal because of inability to pay, and there is no means test. However, all participants are given an opportunity to contribute to all or part of the cost of the meal. Each participant determines for himself what he is able to contribute.

Nutrition Program projects provide at least one hot meal a day, at least 5 days a week, to Americans 60 years and over and their spouses of any age. The meal must provide one-third of the current Recommended Dietary Allowances as promulgated by the Food and Nutrition Board, National Research Council-National Academy of Sciences. The U.S. Department of Agriculture provides a stipulated value of donated foods and/or cash for each meal the Nutrition Program serves.

Provision of meals in group settings is emphasized. Meal sites include schools, churches, community centers, senior citizens centers, public housing, and other public and nonprofit facilities where other supportive services may also be available. Outreach programs identify those older persons most in need.

Although the Nutrition Program was not initially a home-delivered meal activity, it did provide home-delivered meals to regular participants who from time to time were unable to attend the meal service site—about 15 percent of all meals. The 1978 amendments to the Older Americans Act, which incorporated the Nutrition Program into Title III, make specific provision for home-delivered meals.

The Nutrition Program project sites act as centers of activity, attracting older persons to a place where, in addition to a nourishing meal, they have the opportunity to receive other supportive services, including health services, information and referral services, counseling, consumer education, and advice on such important matters as legal rights, housing, income maintenance, and crime prevention. They also have the opportunity for socialization and recreation and for volunteer services to others. Under the Older Americans Act, States are encouraged to make Nutrition Program projects part of the system of services coordinated through area agencies on aging. An important part of the Nutrition Program is health and nutrition education.

The newly enacted amendments require:

- Each nutrition project to provide meals in a congregate setting
- Home-delivered meals to be based on a determination of need
- Each project to establish outreach activities
- The Commissioner on Aging to issue guidelines concerning charges for meals
- Funds realized from meal charges to be used to increase the number of meals served
- Area agencies on aging to continue funding existing nutrition project meeting the requirements established in Title III

The amended legislation provides separate authorization for congregate meals and home-delivered meals provided to persons 60 years and over and their spouses of any age. However, States may, with the commissioner's approval, transfer funds between the two programs as local needs dictate. Cooperation between home-delivered meal programs and congregate meal programs is encouraged. During FYs 1979 and 1980, States may use up to 20 percent of their nutrition allotments for supportive services, such as recreational activities, health and welfare counseling, and referral services. With the commissioner's approval, this percentage increases to 50 percent for States with high supportive costs.

Information and Referral Services. The Older Americans Act requires that all elderly persons in the country be provided reasonably convenient access to an information and referral service. Its purpose is to guide individuals with specific problems or needs to appropriate facilities where they can get help. All the State and area agencies on aging are striving to meet this requirement. In most communities, a separate information and referral service has been set up. The name, address, and telephone number of the nearest information and referral service for the elderly in your community can usually be obtained from the local telephone directory or the State or area agency on aging.

Where to go for more information. A directory of State Agencies on Aging is provided in appendix D. The name, address, and telephone number of the area agency on aging should be shown in the local telephone directory under the list of county government numbers.

Training Programs for Personnel in the Field of Aging

Under Part A of Title IV of the Older Americans Act, as amended, the Administration on Aging is directed to develop and implement a national manpower policy for the field of aging and to make training grants in accordance with that policy. The national manpower policy must reflect present and future needs for training personnel in all programs serving the elderly. Priority is to be given to training personnel for carrying out projects related to multipurpose centers under Part III-B and nutrition programs under Part III-C of the act.

The legislation provides that the commissioner may make grants to any public or nonprofit agency, organization, or institution, or with the State agencies on aging, or contracts with any agency, organization, or institution, to assist them in training persons who are employed or preparing for employment in the field of aging—

1. to coordinate training efforts of all programs serving the elderly at the Federal, State, and local levels
2. to assist in paying costs of short-term and inservice training courses, workshops, institutes, and other activities designed to improve capabilities of participants to provide services to older persons and to administer programs related to the field of aging
3. to assist in paying costs of postsecondary education courses of training or study related to purposes of the Older Americans Act, including payment of stipends to students enrolled in such courses
4. for establishing and maintaining fellowships to train persons to be supervisors or trainers of persons employed or preparing for employment in fields related to the purposes of the Older Americans act

5. for seminars, conferences, symposia, and workshops in the field of aging, including the conduct of conferences and other meetings for the purposes of facilitating exchange of information and stimulating new approaches with respect to the activities related to the Older Americans Act
6. to assess future national personnel needs, including the need for training of advocates, with respect to the elderly with special emphasis on the needs of elderly minority group individuals and the need for the training of minority group individuals to meet such needs
7. to assist in paying the costs of special courses of training designed to meet the needs of service providers in rural areas
8. for the improvement of programs for preparing personnel for careers in the field of aging, including design, development, and evaluation of exemplary training programs, introduction of high quality and more effective curricula and curriculum materials
9. the provision of increased opportunities for practical experience

Program announcements and guidelines are made from time to time, outlining specific program priorities for funding. These announcements are published in the *Federal Register* and are available from the Office of Education and Training, Administration on Aging, 330 Independence Ave., S.W., Washington, D.C. 20201.

Demonstration Projects

Grants for demonstration projects are authorized under Title IV, Part C of the Older Americans Act, as amended. With respect to eligibility for these grants, the Act states: "The Commissioner may, after consultation with the State agency in the State involved, make grants to any public agency or nonprofit private organization or enter into contracts with any agency or organization within such State for paying part or all of the cost of developing or operating nationwide, statewide, regional, metropolitan area, county, city, or community model projects which will demonstrate methods to improve or expand social services or nutrition services or otherwise promote the well-being of older individuals. The Commissioner shall give special consideration to the funding of rural area agencies on aging to conduct model projects devoted to the special needs of the rural elderly. Such projects shall include alternative health care delivery systems, advocacy and outreach programs, and transportation services" (Section 421).

In making grants and contracts under this section, special consideration will be given to projects that are designed to do the following:

1. Assist in meeting special housing needs of older persons by:
    - providing financial assistance to such individuals, who own their own homes, when necessary to enable them to make repairs or renovations necessary to meet minimum standards
    - studying and demonstrating methods of adapting existing housing, or construction of new housing, to meet needs of older persons suffering from physical disabilities, and
    - demonstrating alternative methods of relieving older individuals of burden of real property taxes on their homes.
2. Provide continuing education to older individuals designed to enable them to lead more productive lives by broadening the educational, cultural, or social awareness of such older individuals, emphasizing, where possible, free tuition arrangements with colleges and universities.
3. Provide preretirement education information and relevant services (including training of personnel to carry out such programs and the conducting of research with respect to development and operation of such programs) to individuals planning retirement.
4. Provide services to assist in meeting particular needs of physically and mentally impaired older individuals, including special transportation and escort services, homemaker, home health and shopping services, reader services, letterwriting services, and other services designed to assist such individuals in leading more independent lives
5. Meet special needs of, and improve delivery of, services to older individuals who are not receiving adequate services under other provisions of the Older Americans Act, with emphasis on needs of low-income, minority, Indian, and limited English-speaking individuals and the rural elderly.
6. Assist older individuals to remain within their communities and out of institutions and to maintain their independent living in their own residences or in a family living arrangement by:
    - providing financial assistance for establishment and operation of senior ambulatory day care centers (providing planned schedule of health, therapeutic, education, nutrition, recreational, rehabilitation, and social services at least 24 hours per week, transportation arrangements at low or no cost for

participants to and from the center, a midday meal, outreach and public information programs, and opportunities for maximum participation of senior participants and senior volunteers in planning and operation of the center)

- maintaining and initiating arrangements (or providing reasonable assurances that such arrangements will be maintained or initiated) with any agency of the State involved which administers or supervises administration of a State plan approved under titles XIX and XX of the Social Security Act, and with other appropriate social services agencies receiving, or reimbursed through, Federal financial assistance, for payment of all or part of the center's costs in providing services to eligible individuals

7. Meet special needs of older individuals residing in rural areas.
8. Develop or improve methods of coordinating all available social services for homebound elderly, blind, and disabled by establishing demonstration projects in 10 states, in accordance with the following:
   The Commissioner shall consult with Commissioner of Rehabilitation Services Administration, Commissioner of Social Security Administration, and the Surgeon General of the Public Health Service, to develop procedures for:
   - identifying elderly, blind, and disabled individuals who need social services
   - compiling a list in each community of all services available to elderly, blind, and disabled
   - establishing an information and referral service within the appropriate community agency to inform those in need of the availability of such services; and coordinate delivery of such services to the elderly, blind, and disabled.

Program announcements and guidelines are made from time to time outlining specific program priorities for funding. The announcements are published in the *Federal Register* and are available from the Division of Model Projects and Demonstrations, Office of Research, Demonstrations and Evaluation, Administration on Aging, 330 Independence Ave., S.W., Washington, D.C. 20201

4. Mental Health Program

This part of section IV describes briefly the Mental Health Systems Act which was just approved as this Guide goes to press. This Act should, in the years ahead, have great impact on the delivery of mental health services to the aged. Prior to the passage of this Act, Conversion Grants, which were a part of the Community Mental Health Center Amendments of 1975, were used by some CMHCs to expand their services to the elderly. Many of the examples of CMHC services described in this Guide were funded by these grants. Though no longer available, they should give some guidance to the implementation of the Mental Health Systems Act of 1980 in terms of the type of appropriate services for the aged.

Mental Health Systems Act

The Mental Health Systems Act was signed by President Carter on October 7, 1980. The programs authorized under this Act will be eligible for funding beginning in Fiscal Year 1982. The Mental Health Systems Act came about as a result of the recommendations of the President's Commission on Mental Health. Despite the Mental Health Center's legislation of 1963 which established community mental health centers and made mental health services available to all and despite later amendments to the original law, there still remained unserved and underserved populations. These groups included the elderly, the chronically ill, racial and ethnic minorities, poor persons, the deinstitutionalized, and rural persons. The Act has had four sections which are of particular significance for the elderly, but nearly all sections of the Act are of some relevance to the aged.

The following are the key provisions of this Act which are of importance to the aged:

Community Mental Health Centers
(Section 201)

Grants may be made to any public or nonprofit private CMHC to meet the costs of operating such a center. A CMHC may receive these grants for operation for up to 8 years. The definition of the program and services of a CMHC is included in the law (Section 101) and is similar in most respect to that defined by the CMHC Act. Section 101 does call for CMHCs to give special attention to the chronically mentally ill.

Initially, a CMHC must provide:

- inpatient services
- emergency services
- outpatient services

- assistance to courts and public agencies in screening persons being referred to State mental health facilities
- followup care to the deinstitutionalized
- consultation and education services

Within 3 years a community mental health center must provide:

- daycare and partial hospitalization services
- specialized services for children
- specialized services for the elderly
- transitional half-way house services
- alcoholism and drug abuse services, unless otherwise being provided in the mental health service area.

The CMHC is expected to obtain State, local, and other funds, fees, premiums, and third-party reimbursements. The amount of the Federal grant will not exceed the amount by which the previously mentioned resources do not cover the total cost of operation of the CMHC up to a certain maximum percentage of the cost of operation as follows:

	1st yr.	*2nd yr.*	*3rd yr.*	*4th yr.*	*5th yr.*	*6th yr.*	*7th yr.*	*8th yr.*
Poverty area	90%	90%	80%	70%	60%	50%	40%	30%
Nonpoverty area	80%	65%	50%	35%	30%	30%	25%	25%

The declining percentage and limit of 8 years for CMHC grants reaffirms the philosophy that the Federal role is to initiate services and for the CMHC to obtain State and local funding and third-party reimbursements to become financially independent.

Chronically Mentally Ill
(Section 202)

Grants may be made to State mental health authorities, CMHCs, or other public or nonprofit private entities to provide mental health and related support services for chronically mentally ill individuals. No State, CMHC, public or nonprofit entity may receive more than eight grants under this section. A grant for a project in a mental health service area (formerly a catchment area), served by a CMHC, may be made only to the CMHC or the State Mental Health Authority, unless the Secretary finds exceptional circumstances to indicate that the chronically mentally ill would be better served by another public or private nonprofit entity.

A project under this section must provide for at least the following:

- identification of the chronically mentally ill in the area to be served
- assistance to individuals to obtain mental health services, medical and dental care, rehabilitation services, employment and housing, and other services enabling the individual to function independently of an inpatient facility
- a case manager to assure that the individual receives such services
- coordination of mental health and related support services

Grants may be made to State mental health authorities to:

- improve the skills of personnel providing services to the chronically mentally ill
- coordinate State agencies responsible for mental health and related support services

The amount of the Federal grant will not exceed a specific maximum percentage of the total cost of the program, as follows:

1st yr.	*2nd yr.*	*3rd yr.*	*4th yr.*	*5th yr.*	*6th yr.*	*7th yr.*	*8th yr.*
90%	90%	80%	70%	60%	50%	40%	30%

Elderly Individuals and Other Priority Populations
(Section 204)

Elderly Individuals
(Section 204(a))

Grants may be made to any public or nonprofit private entity for services to elderly individuals. No entity may receive more than eight grants for the provision of services to the elderly. Each grant shall provide at least the following:

- location of elderly individuals in need of mental health services
- provision of or arrangement for the provision of medical differential diagnoses to distinguish between the need for mental health services or other care
- specification of the need for mental health and related support services by the elderly
- provision of mental health and support services in the community including those individuals in nursing homes and intermediate care facilities and training for personnel in these facilities

To the extent that a public or private nonprofit entity is already providing the above services grants may be made to it for any of the following:

- assurance of the availability of personnel to provide or arrange for the provision of services to the elderly
- coordination of the provision of mental health and support services with the area agency on aging (as defined by the Older Americans Act) and other community agencies providing services to elderly individuals

The amount of the Federal grant shall not exceed a specific maximum percentage of the total cost of the program as follows:

1st yr.	*2nd yr.*	*3rd yr.*	*4th yr.*	*5th yr.*	*6th yr.*	*7th yr.*	*8th yr.*
90%	90%	80%	70%	60%	50%	40%	30%

At least 40 percent of the funds appropriated for section 204 are to be used for projects to serve the elderly.

Mental Health Services in Health Care Agencies

(Section 206)

Grants may be made to health care centers to provide mental health services to their patients. Two types of public or private nonprofit entities are eligible for grants.

1. An entity which provides mental health services which includes at least 24-hour emergency, outpatient, and consultation and education service and which has an affiliation agreement for the provision of health and mental health services.
2. A health care center which has in effect an affiliation agreement with a mental health services entity as defined above. Section 203 says, "the term 'health care center' includes an outpatient facility operated in connection with a hospital, a primary care center, a community health center, a migrant health center, a clinic of the Indian Health Service, a skilled nursing home, an intermediate care facility, and an outpatient health care facility of a medical group practice, a public health department, or a health maintenance organization."

An affiliation agreement includes the following:

- description of the geographical area to receive mental health services

- provision for at least one mental health professional to serve as liaison between the two parties
- provision of satisfactory assurances that patients referred will receive mental health services
- provisions for transportation

A grant may be made to provide any one or more of the following:

- the costs of liaison or other professionals providing mental health services in the health care center
- mental health services provided by other personnel of the center
- consultation and inservice training on mental health services provided to personnel of the health care center
- establishment of liaison between center and other providers of mental health services

An entity may not receive more than eight grants under this section. The amount of the Federal grant will not exceed a specific maximum percentage of the total cost of operation as follows:

1st yr.	*2nd yr.*	*3rd yr.*	*4th yr.*	*5th yr.*	*6th yr.*	*7th yr.*	*8th yr.*
90%	90%	80%	70%	60%	50%	40%	30%

V. COMPREHENSIVE SERVICES FOR THE MENTALLY DISABLED ELDERLY

"There is more than one way . . ."

A. Introduction

CMHCs and community-based mental health programs, federally funded and otherwise, have developed around a common set of concepts that have included the provision of inpatient, outpatient, and transitional care and emphasis on consultation and education (public health/mental health approaches), as well as psychiatric treatment of mental illness. However, to be effective and to offer optimal service to its clientele and its community, each CMHC or program has established its own set of priorities and unique functions. A geriatric mental health program begun in an established community-based program will, of course, reflect the operating approaches of its host setting. But, because of the special needs of the elderly, the director and staff of the geriatrics program must be able to make modifications and establish their own objectives and set of priorities. The existence or absence of other community resources for the elderly is a major determinant of what the mental health role and contribution should be in any community. Available staff and fiscal resources are other critical factors.

An examination of the specific program priorities and activities of each of the models discussed in Section III will show the range of program components and emphases that have been found to be useful or productive. The "mix" varies in each center and changes from time to time. In this section, we explicate major program components or areas essential in the delivery of comprehensive mental health services to the elderly, to give examples of various activities or program approaches in each of these areas and to provide some indication of the kinds of resources or sources of funding used to support these activities.

There are several ways in which mental health activities can be categorized. Some have to do with the centrality of a treatment modality used or the presence of a diagnosed illness. Others have to do with staff mix, the period over which a service is offered, or the target group selected for education or intervention. In this section, we selected three broad areas for analysis: Prevention, Mental Health Services, and Education. Most of what is often called "indirect services" is included under Prevention, while direct clinical or treatment services are considered under Mental Health Services. These two areas are really interdependent. While educational approaches are components of these two areas, there are other educational activities that are undertaken as an independent program commitment. The third part discusses both kinds of educational functions.

In each part, there is a discussion of the general concepts underlying the program area, a summary of the kinds of resources that have been used to support activities in the area, and a series of examples of how different centers have put them together. It is hoped that the reader will be able to expand this list of examples and be stimulated to discover many potential resources in his own community. Many of the resources mentioned are not discussed elsewhere in this Guide. They are State, local, or private sources which do not fit within the federally supported programs described in section IV. However, they illustrate the wide range of possible resources.

B. Prevention

Mental health programs directed toward prevention have long-range goals which include:

- Preserving the good physical and mental health of those who are well
- Keeping the mildly ill from becoming more severely ill
- Helping the severely ill avoid increased or prolonged disability and deterioration. For the elderly, this means trying to preserve each person at his best possible level of functioning. It also means helping the general public, particularly family members and those who work with elderly persons, to understand the process and the mental health problems of aging. Serious personal disabilities and even death may be associated with conditions related to mental illness, i.e., malnutrition, exposure, confusion, inability to care for one's daily needs, isolation, accidents, and substance abuse. The confused or senile elderly person is often placed in a mental hospital, nursing home, or

rest home because there is no one to care for him in his own home and he needs shelter and protection. Avoidance of unnecessary institutionalization is a primary area of preventive mental health activities.

Preventive mental health services for the elderly are discussed in terms of the major goals of: mental health promotion, social supports and community services, and health services.

1. Mental Health Promotion

a. Program Focus

Mental health and other human service agencies can play a vital part in providing the elderly with the opportunity for new and/or continued family and community roles and in changing community attitudes toward the aging process and the elderly. Part-time employment, volunteer activities, and courses which teach new skills contribute to new roles and enhanced self-images. Challenging subjects may range from arts and crafts to writing, investment planning, cooking, household repair, and transcendental meditation. Programs concerned with personal, family, or community attitudes toward aging and the elderly and those which have an educational content about mental health, the aging process, and healthy living must be planned around broad population groupings and generalized approaches. All avenues of communication should be used—media, educational institutions, senior citizens groups, church groups, and other community organizations. Special attention needs to be given to reaching minorities and other elderly persons isolated from the mainstream of community interaction.

Usually, community mental health activities in mental health promotion are undertaken in cooperation with some other agency, such as a senior center, a health center, a community college, or a business or civic organization. For example, both industries and unions may sponsor preretirement planning seminars.

b. Resources

Third-party reimbursement for mental health services seldom covers educational activities or training and supervision of volunteers. Some of these activities may be covered in administrative or overhead costs. Usually, other sources of funds must be sought. The nature of these funds may determine the agency or organization that can most appropriately sponsor the educational activity and the role and responsibility taken by the CMHC. Planning and implementing an educational program or a volunteer service program are appropriate for a CMHC program for the elderly. Sources for this type of program may include:

- State/local mental health funds
- Community college funds—"life-time learning programs"
- Older Americans Act—Title IV-A
- National Endowment for Arts and Humanities
- Agricultural Extension Services
- Contracts from industries and unions
- Civic organizations; church groups
- Local foundations or philanthropies
- "Public service time" on local media; local newspapers
- ACTION, other volunteer organizations
- Social service organizations (e.g., Salvation Army, Family Service)
- Out-of-pocket registration fees or tuition

c. Examples

A Creative Retirement Program is sponsored by a CMHC located in a catchment area with a heavy concentration of single retired persons. A group session is held once a week for 4 hours. The group "does their own research," finding answers to their own questions regarding options available for more satisfying retirement years, and invited lecturers bring information on topics of special interest. The teacher (group leader) is furnished by the community college system, and this is considered an adult education program. No fees are charged.

A Senior Block Information Program has been developed for two segments of the catchment area of an urban CMHC. Block volunteers prepare and distribute a monthly bulletin to the seniors in the area. A monthly information and referral training meeting is held for the volunteers. The bulletin contains information of special interest to seniors, for example, a list of all the senior centers in the area, dates for free glaucoma screening at the health center, and special activities in the neighborhood. This activity is funded through Title III of the Older Americans Act.

Resource Guides prepared by staff and volunteers are specially designed for use in each of the different geographic areas covered by one center. These guides have been used as the basis for newspaper, radio, and TV publicity about services for the elderly.

Collaborative work with community and business groups has enabled one center to focus on community attitudes toward the elderly and to try to prevent the isolation and physical deterioration that result from inadequately met needs. Plays have been organized, using people in the community and center staff to familiarize the community with the plight of the aging person and the decisions he has to make. These activities are funded as a part of the center's regular budget which primarily comes from State/county matching money (mental health funds).

Expansion of availability of art programs to the elderly has resulted from the work by center staff in a fine arts museum and a museum school. Tuition stipends have been awarded to 50 elderly who attend art courses at the museum school. Programing assistance is provided for the groups selected, and a referral service is available to individuals with specific interests.

Mental health staff have assisted the museum staff by sensitizing them to the special needs of the elderly. Impairments of the elderly frequently require knowledge of the aging process and functional disabilities, such as incontinence and how to cope with similar impairments of aging. By working with museum staff and other elderly students, the staff were able to overcome one individual's functional limitations and permit the person to actively participate in the art program.

A training program for elderly docents has been developed. This program is a part-time employment program designed to provide training and job experience for the elderly. The training programs involve all aspects of art history and appreciation. The docents work closely with museum personnel to help them develop tours, art programs, and displays which appeal to the elderly population and which are sensitive to their special needs.

Center staff also helped to create a program in which elders with craft experience spend time working with children. The program, situated in an area of the museum called "Grandma's Attic," is organized to bring together children who have not had the benefit of an extended family. At the same time, the program is educational and informative for both the elderly and the children. Many of the elderly individuals involved in the program are artisans, regularly demonstrating the techniques they use in stained glassmaking, ironworking, and breadbaking.

A Senior Activity Center which receives some funds from the local agency on aging is an integral component of CMHC. Small fees are charged for lunch or other food service and for the actual cost of materials used in craft work. Group activities and craft classes are led by volunteers. CMHC staff train the volunteers and work with them in planning, case consultation, and inservice training. Participants find value in group supports, self-expressive activities, and information and referral services.

Elderly persons have been selected by a center to become teaching assistants at a Head Start Program. The interaction between the assistants and the students has proved beneficial to student and elderly alike.

College students and young children volunteers are used by one center to work with institutionalized elderly. In addition, some of the nursing home/retirement home residents themselves volunteer as "Foster Grandparents." The volunteers and residents form socialization groups in the nursing homes, which also include other elderly people from the community who need this contact.

2. Social Supports and Community Services

a. Program Focus

Informal support networks and planned social services are important components of a mental health prevention program. These services are particularly useful for high risk groups, i.e., those persons in danger of losing their ability to cope with the problems of daily living because of age or infirmity and/or of becoming acutely disturbed; those who have suffered a severe loss such as the death of a partner or child; or those persons attempting to reenter community living after a period of institutionalization for either physical or emotional reasons.

In essence, social supports include all informal or organized community services which assist an individual to continue to live in, or to reestablish living in, his own home or in an alternative community residential environment. Institutional settings, for example, homes for the elderly, single occupancy hotels, board and care homes, or intermediate care facilities, may be considered social support facilities, if the care they give is primarily social rather than medical or psychiatric.

Social support services include:

- Income security, financial assistance

- Housing—temporary, emergency, and long-term—Information and referral
- Chore service
- Companion service—part-time or live-in
- Telephone reassurance
- Friendly visiting
- Homemaker services
- Escort services—shopping, health care, banking, recreation
- Transportation
- Legal services—wills, property settlement, guardianship
- Protective Services
- Recreation, group activities, socialization
- Congregate meals, meals on wheels, Food Stamps
- Religious observances

Community mental health programs can probably best serve the elderly by becoming a part of the local (regional) social support system and by helping to expand or solidify it. Organizational leadership is often needed to provide backup and continuity to informal networks. Mental health professionals can make important contributions to support services by helping volunteer or paid staff to understand, accept, and work with the to-be-expected anxieties and emotional problems related to aging and incapacity.

Support service programs are primary areas for finding persons with severe emotional problems and providing crisis intervention or longer term specialized psychiatric treatment. Mental health program staff must be familiar with the range of resources in order to use them appropriately on behalf of mentally disturbed individuals.

b. Resources

Few social support or community service programs have been designed for the mentally ill only. Some are being developed for the "frail elderly," which could include those with mild mental disabilities. Historically, many social support and community service programs were developed by voluntary, religious or philanthropic health and social service organizations. Public welfare agencies and housing authorities have also provided many of these services. The Administration on Aging, through the area office on aging, has sought to expand the services and make them more universally available. Title XX is extremely important to their continued funding. But many resources must be put together to achieve a complete network of support services in any community. ACTION and CETA may be able to provide manpower. Other key agencies include public and voluntary health agencies, protective services, legal service agencies, and fraternal and civic organizations.

Informal networks of social support services are developed through family and neighborhood efforts. There are few, if any, third-party payment programs which reimburse these services. Many elderly persons can use their own funds for support services, if they can find the agency or the individual able to provide them.

c. Examples

Assistance in Independent Living. A telephone reassurance service is maintained by volunteers and supervised by CMHC staff. Persons receiving this service are called every day, to be reassured that, if there is an emergency, someone will take care of the problem. If the senior does not respond to the call, the volunteer contacts the mental health center, so that a professional or paraprofessional can be alerted to the case, and a person who has authority to enter the client's home can follow up. Volunteers are recruited, trained, and supervised as part of the Retired Senior Volunteer Program (RSVP).

Friendly visitors visit seniors in congregate, residential care settings, on request, at least once a week for 1 or 2 hours. The visitors are trained in a basic understanding of older persons' needs and problems and in how to get further assistance when and if it is needed. These volunteers may be older persons themselves in search of a meaningful community role. Six-week (12-hour) training sessions for the volunteers are taught by a teacher provided by the community college system.

Senior aides provide services which assist senior citizens to remain in their own homes. The services provided include: escort service, primarily to medical appointments or agencies serving the elderly; assistance with bank accounts; emergency shopping; and psychological support. The Senior Aide program, based in a mental health center, is funded by the Labor Department through a local Office of Economic Opportunity.

A *working agreement* between a CMHC and a County Department on Aging facilitates support services to elderly clients in need of help in independent living, nutrition, and socialization. The Department on Aging provides opportunity for mental health patients to become actively involved in recreation, social activities and educational programs and, in addition, supplies homemakers, transportation, escort, and volunteer services. In turn, the mental health center is a resource available to the Department on Aging for evaluations, diagnoses, and assistance in the coordination of services with other local agencies. In a rural area, this kind of exchange of resources and expertise has been important. This agreement has led to a countywide intake program and to the implementation of the concept that the elderly person with a mental or emotional problem is best served in a general service agency. The Department on Aging uses Older Americans Act funds to provide services.

A special program for persons in *Residential Care Homes* is provided to 40 of the 102 Residential Care Homes in a center's catchment area and is focused on those persons who have been diagnosed as having some degree of chronic brain syndrome or as being depressed. The program is designed to promote the residents' self-esteem, enhance their social relationships, and improve their physical and mental health. It concentrates on helping them become involved with other people and with activities, including crafts, music, discussions, and exercise. The program is implemented by social workers, a psychiatrist, recreation aides, and volunteers. Three primary services are offered to the residents: a weekly group session lasting from 2 to 2½ hours, conducted within the Residential Care Home; a workshop, conducted once or twice a month at a church or senior center or recreation facility away from the home and involving residents from more than one home; bus ride, once or twice a month. In addition to the resident services, consultation regarding individual residents' problems, as well as general Residential Care Home problems, is made available to home administrators. This activity is supported by center operating funds, mostly a State/local mental health fund match.

Outreach workers in one center function as the primary source of *information and referral* for the chronically ill and elderly living in the community. These persons are made aware of and connected to a service or resource that can appropriately respond to an individual's needs. Outreach workers also assume a referral "brokerage" role in that program staff: identify and coordinate resources which are not duplicative and monitor the appropriateness and use of services, maximizing continuity in services and resources available in the catchment area.

A protective services/legal aide role is frequently assumed by center outreach workers. Through community contacts, outreach workers play a watchdog role to protect or identify others to protect aged individuals whose physical and/or mental capacities are so limited that they are a danger to themselves or may easily become victims of exploitation by relatives and others. In this area, center staff make referrals to legal aid services; submit petitions to courts on behalf of allegedly abused or neglected aged persons; participate in court hearings; and arrange for appropriate guardianship as necessary. Again, center staff act to mobilize existing protective service agencies. Informal agreements have been developed over the last several years between center program staff and the protective service agencies concerning how agency's responses are coordinated.

Transportation to and from community facilities and resources is an effective means of maintaining maximum independence for the isolated elderly. In one center, the Mobile Mental Health Unit provides transportation for the elderly to do shopping, laundry, and pay medical and social visits. Private foundation grants have been used to enable this service to operate on a full-time basis.

Multipurpose Senior Centers.

A CMHC, by itself, cannot readily duplicate all the kinds of program activities and social support services that are components of most senior centers. With the network of some 700 senior centers throughout the country, the development of *CMHC–senior centers linkage* is essential in every community.

Many CMHCs have developed patterns of relationships with multipurpose senior centers which are designed to address broad mental health goals. These relationships promote (a) the incorporation of mental health concepts into a variety of community education and "promotion of well-being" activities designed for the elderly; (b) early identification of persons with emotional or mental problems; (c) case assessment, planning, and management in a nonthreatening and nonstigmatized setting; (d) access to social support, information and referral, and other services for mental health center patients; (e) more concerted efforts in community planning and in advocacy for the needs of the elderly and the mentally ill. Some organizational relationships are determined by working agreements and joint access to services or benefits, or exchange of services. In others, there may be an exchange of funds; contract arrangements for payment for specific services, e.g., consultation, staff teaching; co-mingling of program grant or matching grant-in-aid funds, or joint administration within an umbrella agency.

Senior centers are usually financed by a mix of Older Americans Act funds and State and county moneys. In some places, general revenue sharing funds can be added to this mix. In others, State and county mental health funds may be allocated to a center as a part of a working agreement. Additional activities may be funded by RSVP, CETA, Title XX, DOT, adult education, local United Way, and private philanthropic moneys.

Interagency Coordination.

A coordinating council for senior citizens established in a rural county provides an umbrella agency for the delivery of a number of services to the elderly, similar to those that might be put together in a senior center elsewhere. These services include transportation, meals-on-wheels, homemaker services, social and recreational services, partial employment, legal assistance, the beginning of certain medical and nursing services, and information and referral. The CMHC serves as a coordinator of the delivery of these particular services needed by its patients. In order to be effective in this coordinating role, the CMHC staff must maintain ongoing liaison with the coordinating council and with many individual agencies. These liaison activities include formal meetings, informal and frequent staff contacts, and participation of center staff in clinical conferences of other service agencies. To further interagency communication, each agency that has occasion to make frequent referrals to the center has been encouraged to appoint a liaison to the center.

3. Health Services

a. Program Focus

Timely and appropriate provision of primary health care is a fundamental component of mental health care of the elderly. It can do much to prevent or postpone incapacity and institutionalization. Most elderly persons with acute or chronic mental or emotional disturbances also have one or more physical problems. Many elderly persons would prefer to receive mental health care as part of general or primary health care services, rather than through a separate care program. Close linkage between the mental health program and health care providers must be developed in any geriatric mental health service as a component of both preventive and treatment services.

From a mental health point of view, it is important that health services be provided with an understanding of the emotional needs of the individual and with an awareness of the changes brought about by the aging process in both physical and mental capabilities. There needs to be an appreciation of appropriate therapeutic approaches and goals for the elderly in terms of individual needs and capacities. Stereotyping by age and disease categories can hasten both chronic disability and disorientation.

The mental health role in relation to health services has several aspects: (1) to see that high risk individuals have access to comprehensive health services; (2) to see that there is appropriate linkage between health and mental health services; and (3) to promote understanding of mental health aspects of health care and emotional needs of the elderly among primary health care providers.

b. Resources

The elderly have the most complete health insurance coverage of any group in the country. Medicare and Medicaid cover acute care in general hospitals and physicians' services in hospitals and ambulatory settings. In addition, many of the elderly carry supplementary private health insurance. However, limitations exist in all of these programs in the areas of health-related preventive activities and, with the exception of Medicaid, in long-term health care. (See Section IV.)

While third-party payments reimburse for direct health care services, other sources of funds must be found for the more generalized or educational activities. Some of these sources include:

- State/local health departments
- Health revenue sharing
- Special projects of fraternal and civil groups
- Health provider support of continuing education for staff
- Individual fees
- Contracts with industry and/or union health care plans

c. Examples

A monthly bulletin, published by a CMHC, is distributed to seniors throughout its catchment area. Each issue contains information about free health services or health screening available at health centers in the area.

A working relationship with a rehabilitation institute enables one center to give a *lip-reading course* to assist hard-of-hearing patients.

A staff nurse has been assigned to provide health services for the center clients including basic screening, health education, and work with family physicians and hospital clinics. She has also developed a blood bank program.

A physical examination is a routine part of assessment procedures in many CMHCs. This may be done by an internist who is a member of the home-visit assessment team or in the outpatient unit of the general hospital with which the center is affiliated.

One center has placed an internist on the *assessment team to formulate treatment plans* in consultation with the patient's physician. The treatment plan includes several aspects covering psychosocial physical care needs. In addition to psychiatric treatment and followup from the geriatric staff, the plan may include medical hospitalization and referral to home health care services, visiting nurses association, and geriatric day center.

One center has a *medical person on call on a 24-hour basis* to respond to requests for consultation from physicians in the community. A visiting nurse on the center staff helps with followup. Many patients are seen in the general hospitals and nursing homes in the community and are followed up through working with their own physician.

A center assigns *mental health staff to accompany home health service teams.* Mental health staff can provide consultation to the home health staff and counseling to the patient. This kind of collaboration also leads to the identification of individuals who need more specific mental health evaluation and/or treatment. Referrals are then made to the center.

Center staff provide *case-related consultation* to many health providers, including discharge planners in general hospitals, nursing homes staff, and chronic disease hospitals or regional treatment centers for the elderly.

C. Mental Health Services

1. Program Focus and Description of Specialized Services

Mental health treatment services may be seen as the core of the geriatric mental health component of a CMHC program. Actually, centers vary on how much of their total staff effort and resources they put into treatment services, reflecting, in part, the orientation of both the staff and the funding sources, and the center philosophy as well as total community resources. If a center is one of the many treatment resources in the area, it may concentrate on diagnostic screening and referrals. Centers with established inpatient units for adults of all ages seldom see the need for establishing a separate inpatient unit for the elderly. The specialized geriatric mental health staff then concentrates on consultation with the inpatient unit staff about the special needs of the elderly. This same pattern may occur in outpatient treatment services, although it is more likely that specialized geriatrics staff provide more direct outpatient treatment than consultation with other staff.

Specialized mental health services for the elderly include:

Crisis or emergency services—Emergency home visits, assessments, consultation with health providers, family, or police.

Treatment planning, care management, and monitoring—Usually multidisciplined, including mental and physical evaluation. After a treatment plan is developed, a staff member is assigned to assist the individual in obtaining the social supports and health or mental health services he needs and to do followup monitoring.

Home care—This involves periodic visits by a mental health professional to the patient's home or place of residence, such as a nursing home or home for the aged. Psychotherapy, followup on medications, attention to the psychological environment, referral to social support services, and consultation with family or caregivers, e.g., nursing home staff, are all elements of home care.

Geriatric Day Care (Day Treatment Programs)—Day hospital or partial hospitalization programs are traditionally required components of a CMHC. A number of centers have established separate programs for elderly patients, making it possible to pay more attention to the physical health care needs of the elderly, along with their needs for socialization and for a psychotherapeutic environment. Some geriatric daycare programs have been designed to serve persons whose primary problems are physical disabilities and persons whose major difficulties are mental or emotional.

Residential Care—Intermediate care in the general health care system is considered to be health-related residential care, less than skilled nursing but more than board and room, provided to persons who need this care because of physical or mental disorders. Most Intermediate Care Facilities (ICF) have a large percentage of patients who have some mental disability. Some CMHCs, through direct individual and group services and consultation, have sought to make these ICFs more responsive to the mental health needs of residents. A few CMHCs have arranged joint staffing so that a ward or unit of an ICF could become a psychiatric intermediate care facility. To some extent, State licensing requirements, as well as reimbursement requirements, may determine how this can be done.

There are few halfway houses for elderly persons only. However, a number of congregate housing arrangements have been worked out by CMHCs for their elderly patients. These include supervised components of public housing units, homes for the aging, county homes, board and care homes, individual placements in halfway houses planned for younger persons, and cooperative housing arrangements. Other kinds of facilities have included converted staff residences located on the grounds of public institutions and, for limited time periods, camp sites or park facilities. Continued programmatic support and resident involvement are essential to the success of these residential care arrangements.

2. Resources

Third-party payments, including Medicare and most Medicaid plans, cover acute psychiatric inpatient care and some outpatient psychotherapy. Longer term psychiatric care in mental institutions (certified as psychiatric hospitals) is covered in many States by Medicaid. Skilled nursing and intermediate care may be covered by Medicaid in some States, as is geriatric daycare. Medicare may pay for day treatment as an outpatient service. Payments for home care are limited as are those for emergency services, treatment planning, and care management. The best payment approach, for the present, is to treat these as outpatient clinic visits for payment purposes. Title XX may pay for some aspects of home care, daycare, and residential care.

Staffing grants and State/local matching funds are prime funding sources for the core geriatrics team.

3. Examples

a. Emergency Services—Crisis Intervention

A center in a rural area uses a *geriatric nurse or psychiatrist for crisis intervention in nursing homes*. This use may take the form of emergency evaluation which could result in transfer to the inpatient unit or consultation to the nursing home staff about the help the person needs.

A center with a highly organized intake and treatment program generally plans for the *intake visit to be done in the person's own home, board and care home, nursing home, or hospital*. Referrals may be made by anyone in the community concerned about an elderly person or from the older person himself. The center geriatric staff members are designated to evaluate patients for voluntary or for involuntary services under State statute. Under these provisions, involuntary treatment may be indicated if a person is found to be a danger to self, a danger to others, or gravely disabled as a result of mental disorder or alcohol. "Grave disability" is defined to mean that "the person, as a result of a mental or alcohol disorder only, is unable to provide for food, clothing, shelter, and is unable or unwilling to accept services voluntarily." All three aspects must be present in order to meet the definition. Significant information concerning medical, psychiatric, social, and financial history is elicited by the intake social worker at the time of referral. If the situation is of an emergency nature, a home evaluation visit is arranged for that day or the next day, depending on the circumstances. The intake visit is usually done by the intake social worker and a psychiatrist. Depending on the circumstances described, the internist may also be present on this visit. The social workers as well as physicians may sign for involuntary admissions for evaluations up to 72 hours, if necessary.

b. Screening-Assessment-Evaluation-Intake

A Home Evaluation Team, consisting of social workers, a nurse and a consulting psychiatrist, provides individual evaluation for people who are having emotional problems and are unable or unwilling to seek outpatient treatment or come to an inner-city mental health center. The team is concerned with emotional problems ranging from mental illnesses to life crises, such as death of a spouse, adjustment to new living conditions, or health problems. The team assesses what services are needed and helps the patients obtain these services. Referrals include inpatient care; outpatient therapy; day treatment care; supportive services (meals-on-wheels, home health services, attendant and respite care, financial counseling); or a new living arrangement (apartment, senior hotel, residential care center, or nursing home). Under State statute, the members of the team may have a patient involuntarily committed to a psychiatric facility for observation, but they attempt to avoid using this authority. Their goal is to enable the patient to stay within the community. To this end, they attempt to develop a support system, using the help of other social service agencies, family, friends, and neighbors.

One center used the Federal Conversion grant to establish a *Geriatric Mobile Mental Health Unit* with four staff members (a Unit Director, social worker, nurse, and mental health assistant). This team handles assessments and direct mental health intervention in senior centers; goes into nursing homes, hospitals, and boarding homes to do emergency interventions and followup, and handles mental health problems of the elderly on an emergency basis. The assessment includes physical, social, and psychiatric evaluations. The physical examinations are completed at a local community hospital and are reimbursed separately through third-party payments from Medicare and/or Medicaid.

The geriatric mobile mental health team develops a service plan and some therapeutic intervention, e.g., group or individual counseling, medication. The team also performs followup functions when an older client is referred by the team to another unit in the center, e.g., day hospital, older adult center, or inpatient unit. It does not try to arrange nursing home placements because they are time consuming, but it refers the patient to a senior center program for this service.

One center has learned that most *intake of older people is by telephone*. Most calls are from family members, friends, the police, or social service agencies; very few are from the patients themselves. Even fewer older persons take advantage of walk-in clinic resources. At the center, all intake calls are handled by the home evaluation team. Where appropriate, a home evaluation visit is scheduled, and normally a team of two—usually a social worker and a nurse—makes the home visit. If at that time a medical examination seems appropriate, arrangements are made for one. The home evaluation team works out a service plan and makes referrals to various service components, including inpatient care.

c. *Treatment Planning-Case Management*

Intake to mental health services in one area is done *either through the mental health center or the Department on Aging*. When a consumer approaches either agency, one of the intake workers has an assessment interview and decides whether the client requires intensive mental health treatment or whether he/she needs activities which will help to offset loneliness and isolation. After this initial assessment is completed and the services needs of the individual are formulated, there is a joint staffing between the mental health center and the Department on Aging. As a result of this case management staffing, the client is placed either into direct services under the mental health center or the Department on Aging or into both, with one of the agencies taking the prime case management role. Followup on the consumer/client/patient is a joint venture in which discussion takes place, informally and formally, at specific intervals, around meeting the objectives of the case management plan, the possibility of an expansion of services, and reevaluation of the management plan. The mental health center staff psychiatrists and nursing team provide medication management and general monitoring of physical health needs. When needed, referrals to other physicians or health care resources are coordinated by the nursing team. The center described above also has an intermediate services team which has specific responsibility for liaison with nursing homes and boarding homes, for training for nursing home staffs, and for supportive services to clients extending beyond 6 weeks.

In another center, after the initial evaluation—usually in the individual's home—the disposition or *treatment plan is formulated between patient, family, and the team social worker, psychiatrist, or internist, and in consultation with the patient's physician*. Generally the treatment plan includes several aspects covering psychosocial and physical care needs. Referrals may be made for inpatient psychiatric or general medical hospitalization, continued home visits from the center staff of geriatric specialists, and for home health care services. The treatment plan may include daily contacts until the crisis is resolved. Followup contacts may occur on a weekly, biweekly, or monthly basis. Patients placed out of the city are seen monthly or quarterly, depending on the location of their placement and their needs. Individual, family, and medication therapies can be provided in the patient's home or in the center.

A twice-weekly staff conference is scheduled to review cases with the total geriatric staff. All cases are reviewed at least once, more as needed for revision of the treatment plan. The social work staff serve as the main case coordinators. All patients are assigned a social worker and psychiatrist. These staff assignments remain the same from intake through treatment and followup to point of closing the case.

One program has begun a case management project to study the effects of pre-admission screening and case management on individuals who currently are or would be placed in a nursing home. The purpose of the project is to assess the impact of a coordinated community approach (through identification and maintenance of appropriate placement/support resources) on reducing the social and emotional isolation of nursing home patients. The project design includes approximately 250 elderly patients who currently live in five intermediate care facilities.

The primary objective of a case management/screening program is to ensure that community-based services are actively considered for persons in need of long-term care and to maximize appropriateness of placement with respect to site and level of care. The concept of case management/pre-admission screening takes as its principle assumption that inappropriate use of nursing home beds is best prevented by intervention prior to institutional placement. The program adopts this principle, but the case management model it operates is unique in that it has been designed to include the nursing home site as a point at which active intervention should occur for case management purposes. The model project was initiated to demonstrate an active intervention strategy which provides case management for persons already living in long-term care facilities. The program is an attempt to broaden the options for living and support which are available to persons currently institutionalized. Staff have found that in many instances, because an individual or family was not aware that noninstitutional service options were or could be made available to them, the person entered the long-term care facility without considering the possibility of remaining less dependent and continuing to live with noninstitutional support services in the community. It is this facet, assessment and intervention within the long-term care facility, which distinguishes this case management program from other models.

The case management program generally may be described as staff activities which are necessary to manage the provision of social, medical, psychiatric, rehabilitative, or educational services necessary and appropriate to meet the needs of an individual. The case management function begins with the formulation of a resident profile, using a comprehensive assessment instrument developed by the program, which is used by a multidisciplinary team to map out the options for arranging services for the individual. The mutidisciplinary team is made up of internist, psychiatrist, social workers, occupational therapists, and nurses. The profile consists of background history and sociodemographic information and items on social supports, health status, and functional level. The profile is also used to document whether or not the individual can be cared for in the community and what services (if available) would permit the individual to remain at home or in the community in a less dependent living environment.

An essential element of this project is the purchase of case management services from the public home care agency in the catchment area. It is through the combined efforts between the multidisciplinary team members and the services purchased from the home care corporations that community-based resources are marshaled to strengthen informal support systems. Program case managers will also strive to encourage noninstitutional placement by monitoring hospital discharge planning efforts. Discharge planners are assisted to become aware of and locate alternative community placements and to facilitate coordination and better use of resources between hospitals and community agencies that provide noninstitutional services.

Program staff have placed substantial emphasis on the development and application of an assessment tool which is used to measure the effectiveness of this planned case management approach and to compare and contrast this approach with the more traditional crisis-oriented case consultation methods used previously.

d. Outpatient Clinical Services

One center has built most of its program around a well-established *outpatient psychiatric service* directed specifically to the elderly. The wide range of clinical services include: assessment; individual counseling or psychotherapy; family counseling; group therapy; psychotropic drug management; environmental assessment and modification; administrative, legal, and protective services; medical services; and nursing services. It is interesting to note that 70 percent of patients receive some medication and that family counseling and home visits are each used in about 50 percent of cases. Twenty-five to 30 percent of patients have impaired physical functioning. This center is a university-affiliated teaching facility and thus is able to provide highly organized treatment services.

One center holds weekly *Medication Clinics* for home care patients and nursing home residents. Nursing home staff bring residents for medication review and for brief consultation with the psychiatrist.

In addition to emergency evaluations, one center provides *followup services* which include casework, individual and family therapy, group therapy, medication, placement, and referrals. Most of the followup services are provided via visits to the home, board and care homes, medical facilities (hospitals), or nursing homes. Group, individual, family, and medication therapies are available in the office, if the patient is able to come in.

e. Inpatient Psychiatric Treatment

In most centers studied this service is an *age-integrated service* with little or no special staff or program for elderly patients.

In one center, a geriatric nurse is assigned as case manager for all aging persons receiving inpatient treatment within the center. The treatment unit is "free-standing," i.e., not a part of a general or psychiatric hospital. In this facility, the geriatric nurse and the psychiatrist also work with ward staff to help them understand the unique needs of the aging patient

In another center, the *Geriatric services staff*, with the agreement of the inpatient staff, provide inpatient clinical services to the elderly patients hospitalized on the inpatient unit. The inpatient staff provide all nursing services and 24-hour psychiatric case. Geriatric services staff assist with treatment planning, discharge planning, attend a monthly joint staff meeting, and participate in inservice training programs.

f. Day Treatment

One center maintains a *Geriatric Day Treatment Program* which is open 5 days a week from 10:00 a.m. to 3:00 p.m. Specific modalities include milieu therapy; psychiatric evaluation; medication therapy; counseling; socialization; recreational and art therapy, and coordination of social service and medical needs. Limited transportation is available for participating clients. Clients who can benefit from the center are those who have both active and chronic psychiatric problems. People whose primary problem is an organic brain syndrome (inability to concentrate, disorientation to time and place, gross memory loss) are generally unsuited to the program.

An urban center conducts a *structured program providing socialization, activities, and a hot meal* for moderately confused, isolated, or depressed elderly. It meets 2 days a week (10 a.m.–2 p.m.), is staffed jointly by geriatric services and community college personnel, and uses senior aides, nursing students, and volunteers. Transportation is available from a community health agency and a community recreation center for the handicapped. Referral to the program and clinical backup are provided through the center's geriatric services unit.

Another center used a foundation grant to initiate a *Geriatric Day Hospital* located in the hospital of one of its member agencies. This program is geared to disabled elderly who have psychiatric problems associated with their physical illnesses. Medical services are purchased through a contract with a health maintenance organization. Nursing, social service, physical and speech therapy, recreational therapy and other supports are built into this day treatment service. Clients receive transportation to and from the program. The service also has arranged to receive Medicaid reimbursement, and efforts are underway to qualify for Medicare coverage. This program is growing rapidly. A grant has been awarded from the city Community Development Office to renovate a building that is being donated for the day treatment service. This move will allow the program to function as a freestanding facility and save about $30,000 in rental fees annually.

A geriatric mental health services active day treatment program has provided *partial hospitalization services* for the center's inpatient services and aftercare and for persons residing in nursing homes. The goal is that through increasing the availability of this type of active day treatment program there will be a reduction in the need for full-time care for the aged population living in the community. In the fall of 1979 the program will expand its scope to make active day treatment services available to elderly people residing in the community. The staff offer a highly structured and individually tailored treatment plan for each participant which includes careful initial assessment and periodic review.

The program components include psychotherapy (individual and group), nursing treatment, occupational therapy, socialization, recreation, nutritional services, and assessment and evaluation of psychological and physiological problems. The program operates 6 hours each day, 5 days a week. Each elderly patient is assigned to a first year resident and a social worker who are backed up by medical/psychiatric consultation and supervision. The day treatment staff is directed by a psychiatric nurse under the Geriatric Mental Health Program Director's supervision and includes nurses, social workers, occupational therapists, students and volunteers.

g. In-Home Care

One center has developed a *visiting mental health worker or visiting nurse* program for aging patients as an outgrowth of an Aftercare Program for patients who were returning to the community from the State hospital. These services have been extended beyond a person who has been discharged from a State hospital to include anyone referred for this particular purpose. Referrals are accepted from the community and from private psychiatric facilities. Persons are seen in their own homes or in retirement homes where they may be living. This program is staffed by a geriatric nurse and community aides. Homemaker and housekeeping services are provided by the local Department of Social Services.

A center that is a part of a large consortium of services relies on the local area agency on aging for in-home services. The Older Adult Service has in-home service coordinators who make assessments and reassessments and broker the homemaker service from a number of private home health agencies. The funding for these services varies somewhat from year to year. They include Title XX State-appropriated funds and 25 percent county matching funds.

h. Services in Nursing Homes

One center, with a multicounty rural catchment area, concentrates on providing services to elderly persons in nursing homes. Some of these services are financed through third-party payments and through agency contracts. The center can provide *case-oriented consultation, program oriented consultation, socialization programs for residents, and diagnostic and treatment services.* One-half day per week of the Community Service psychiatrist's time is devoted to nursing home consultation, and another psychiatrist is available for on-call consultation. A geriatric nurse is involved in visits to individuals in nursing homes to carry out consultation orders of the psychiatrist and to consult with the nursing home staff regarding treatment plans for individual patients. Social work consultation is provided to both the social work designee and to administrators. The center also has organized volunteer groups to do friendly visiting in nursing homes and to assist with socialization group activities. The lack of third-party payment and contract monies has apparently curtailed the expansion of this service, so not all homes in the catchment area are covered.

There are about 50 nursing homes in one center's catchment area with approximately 3,000 beds—most of them filled by elderly, about half of whom could benefit from some form of *mental health intervention*. The center staff provide the same direct services to elderly living in long-term care facilities as is provided for persons living in their own homes. Staff also offer client-centered case consultation, programmatic and administrative consultation, workshops, seminars, staff development, and leadership training to nursing home administrators and staff.

i. Case Coordination

One center estimated that approximately 75 percent of the patients seen in the *outpatient clinic* require coordination of services. Designing an appropriate service program, providing information about available sources for help, making referrals to other agencies or professionals, and coordinating this service program are seen to be essential tasks in working effectively with the elderly. "Integrated services" include arrangements for a homemaker and household services, homebound nursing services by public health nurses, social and recreational services, and transportation.

In one center program, the outreach staff follow patients who are institutionalized and participate in *development of treatment plans and implementation of discharge plans.* This procedure is used for both those elderly who reside in the long-term care facilities or in the community and who may at some point require hospitalization or intensified active day treatment. Crossing agency and clinical/disciplinary service lines through case planning, monitoring, interagency linkage and advocacy roles, these outreach workers strive for the most practical and logical strategies for improving support and care of the chronically ill and elderly. The outreach workers concentrate on the continuity of care delivered to individuals irrespective of their living or support arrangement. Continuity of care organized by the same individual is especially desirable for the elderly person for whom constantly changing names and faces may dramatically increase confusion and anxiety. By becoming knowledgeable about social systems which had broken down and led to the patients institutionalization (in either a hospital or nursing home), the geriatric team acts to replace, substitute, coordinate, and mobilize the resources which are necessary so that a breakdown in support is not repeated.

D. Education

1. Program Focus

Educational activities or training programs, in their broadest sense, are a major component of all CMHC geriatric mental health programs. Activities directed toward prevention, enhancement of social support and health care systems, and direct mental health care all have substantial educational content. Some centers may use training strategies more than any other modality in the development of their geriatrics program. These centers may devise innovative approaches to both training and service. Other centers, affiliated with academic institutions, may have to emphasize more traditionally clinical approaches to service delivery.

Training starts with center staff to help them become more knowledgeable about the aging process and the mental health potential and problems of the elderly. This same content is important to staff in all mental health, physical health, social, business, educational, and other community programs or groups working with the elderly. The elderly themselves comprise another large trainee group with a need to learn more about themselves and to learn how to become helping persons to their family and peers. Family members are also in need of training, particularly those who are faced with caring for persons with severe long-term mental or physical disabilities or persons who are dying. Many of these educational or training approaches are discussed in the section on prevention.

Academic affiliation carries with it certain commitments to fulfill curriculum and credential requirements. This may mean a substantial allocation of staff time, which may or may not be reimbursed by the training center. Some training centers may assign full-or part-time faculty to the center, in addition to full-time or part-time trainees. These arrangements can become a significant resource to the center and can serve to give greater visibility to the geriatrics mental health program.

2. Resources

Third-party payment programs seldom provide direct reimbursement for training activities. However, many provider requirements for licensing accreditation, or participation in health insurance programs, mandate ongoing staff development or inservice training. It may be possible to include costs of these required activities within overhead in the calculation of reimbursement rates. Specific training projects for health services and social services providers may be undertaken through contracts with providers or through contracts with a local or State health or social service agency. There are staff development or training funds available to the agencies responsible for the administration of Medicaid, Title XX, and the area agency on aging programs which may be used for contracts to fulfill the purposes of these programs.

Continued education credits are now prerequisites for licensure or certification of various health/mental health professions. Center staff may have expertise in subject areas of importance to physicians, nurses, social workers, psychologists, lawyers, ministers, and other professionals. Examples of subject areas are "psychosocial components of chronic illness," "psychological care of the dying," "sexuality and the older person," and "mental health problems of the elderly." Registration fees can help to underwrite the costs of this kind of center activity.

Some communities and States have extensive adult education programs. Through affiliation with these programs, centers can reach a number of community groups, including persons preparing for paraprofessional or technical jobs and older persons preparing for retirement or second careers. Adult education funds may become another source of revenue for the center.

3. Examples

a. Staff Development—Continued Education for Mental Health Personnel

One center offers a twice monthly *seminar* for staff and interested geriatric staffs from other CMHCs in the city. The seminars are coordinated by the staff psychiatrist, a nationally known expert who has done research and writing in the field of geriatrics. Subjects have included psychological aspects of aging, medications, specific psychological disorders and treatment, physical and medical treatment aspects of aging, and cardiopulmonary resuscitation.

A center which functions through many different community units has a once-a-month formal *inservice training session* at which staff from all the units learn about activities relating to aging which are going on within the multi-agencies forming the center and within the community.

A center in a rural area has an annual intensive inservice training program for staff other than professionals in the center program. This is particularly geared toward the inpatient staff and involves special presentations on issues dealing with psychiatric treatment. Time is spent looking at the special needs of the aging person in the hospital.

b. Consultation and Education for Health and Social Service Workers

One center has a contract with the local Nursing Home Administrators Association and has provided *workshops* periodically on administration and the needs of the elderly. The center administrator is a leader in the field of hospital and mental health administration and can assist the nursing home administrators in meeting their recently established continuing education and certification requirements. This center also provides educational opportunities for staff members of personal care homes, as well as the community at large, in the hope that they will provide knowledge with regard to the process of aging that will be of help to the elderly wherever they may be. This help may be related to a person's own aging process, their aging parents, relatives, or persons with whom they work. Other workshops are targeted for teams of nursing home personnel, including administrators, nurses, nurse aides, and activities personnel.

A center in an urban area provides an average of 100 hours per month of *information, consultation, and education services*. This includes inservice training programs for public health nurses, home health agencies, senior activity programs, churches, congregate meal programs, convalescent hospitals, board and care facilities.

c. Educational Programs for Special Target Groups

One center is working with local industries to provide *pre-retirement group education and counseling*.

Several centers provide *educational programs for nursing home staff* as the major thrust of their work with and for the institutionalized elderly. Some of these educational activities are funded by the area agency on aging.

One center developed an overall design for a curriculum of *separate modules concerning mental health issues* as they relate to specific impairments which are "predictable" results of normal aging as well as those which reflect disease. The information is to be directed for use by long-term care staff; however, the materials will be made available to both consumers and professionals interested in the area. A preliminary list of modules has been identified for possible curriculum development.

d. Academic Affiliations

A center which is based in a university medical school maintains a number of *teaching affiliations* and relationships which make teaching a high staff priority. It also provides trainees as full-time or part-time staff. Some of the arrangements are based on specific contracts and payments. Other arrangements are on an exchange or in-kind basis. Teaching affiliations which have different patterns and requirements have been established with:

- The Family Medicine Program in the Department of Community Health Sciences. Family Medicine residents rotate through the clinic, learning assessment techniques and techniques of mental

health service to the elderly. In addition, they provide physical examinations when necessary.
- The School of Nursing-Student nurses rotate through the clinic to learn assessment techniques and modes of intervention with elderly individuals. They contribute nursing services and nursing consultation to those elderly individuals needing such services and are supervised by gerontological nurses.
- Department of Psychiatry, Geropsychiatry Program, and Division of Medical Psychology.
- Pastoral Counseling Service, Practicum.
- School of Law, teaching and consultation.
- School of Social Work, field placements and teaching.

A center provides placement for college students from two nearby State colleges. These students are assigned through the departments of Social Work, Sociology, Psychology, Nursing and Gerontology. Exceptional students are recruited by the county personnel department and are encouraged to make application to be placed on the County Merit System Register. Thus staff vacancies are filled by persons who are known to be devoted to their particular field of endeavor and who have had experience with the county programs in the form of student placement.

Another center provides teaching affiliations for occupational therapists and psychologists, as well as residents in psychiatry and field placements for nurses and social workers.

APPENDIX A. SELECTED REFERENCES

Catalog of Federal Domestic Assistance
Office of Management and Budget for the Executive Office of the President

The Catalog is a governmentwide compendium of Federal programs which provide assistance and benefits to State and local governments, public and private organizations and institutions, and specialized groups and individuals. The 1978 edition of the Catalog covers 1,074 programs administered by 56 Federal agencies. The Catalog is updated on a continuous basis, deleting obsolete programs, adding new ones, and revising existing ones as Federal legislative authorizations change. Each program is listed individually, and each listing explains the nature and purpose of the program; specifies who is eligible to apply and who benefits; tells the kind of credentials/documentation needed to obtain the assistance; describes the application and award process, including deadlines; provides financial information for 3 fiscal years; identifies available printed material, such as regulations and guidelines; lists information contacts, including the administering office and regional and local offices and their addresses and telephone numbers; shows closely related programs.

How to order:

By subscription from Superintendent of Documents
U. S. Government Printing Office
Washington, D.C. 20402

Current price: $20

In many communities, the Catalog may be available in local libraries.

Funding in Aging—Public, Private and Voluntary, 1979 Edition
Adelphi University

This is a comprehensive, high quality source of information about funding resources in the field of aging. It covers federally funded programs concerned with and relevant to the aged. One section of the book on "State Funding for the Aged" details all programs initiated and funded by State governments, as well as referrals to those Federal programs that are administered by the States. The second half of the book looks at private and voluntary sources of funding and assistance, divided into "Corporate" sources of funding, "Foundation Giving," and "Voluntary" organizations, including national associations dealing primarily or significantly with the aging, denominational organizations, professional, service, and fraternal organizations. This book is highly recommended to anyone interested in the field of aging who is seeking funding and technical assistance.

How to order:
Adelphi University
South Avenue
Garden City, N.Y. 11530

Current price: $18.80 (includes postage and handling)

Issues in Mental Health and Aging
National Institute of Mental Health
Center for Studies of the Mental Health of the Aging

This is a set of three volumes: 1—Research, 2—Training, and 3—Services. It contains papers presented by experts in mental health and the aging and summaries of discussions at a series of conferences which launched the Center for Studies of the Mental Health of the Aging. The conferences provided opportunities for intensive discussions of issues and ideas necessary to develop a national effort in the area of mental health and aging.

How to order:
National Institute of Mental Health
National Clearinghouse for Mental Health Information
Public Inquiries Section, Room 11A–21
5600 Fishers Lane, Rockville, Md. 20857

Volume 1, DHEW Publication No. (ADM) 79–665
Volume 2, DHEW Publication No. (ADM) 79–665
Volume 3, DHEW Publication No. (ADM) 79–665

Individual volumes may be requested separately.

Report of the Secretary's Committee on Mental Health and Illness of the Elderly
DHHS Office of Human Development Services, Federal Council on Aging

The Committee on Mental Health and Illness of the Elderly was established by the Congress (Public Law 94–63) on July 29, 1975 to conduct a study and make recommendations to the Secretary of Health, Education, and Welfare for submission to the Congress in three areas: (1) future needs for mental health facilities, manpower, research, and training to meet the mental health needs of elderly persons; (2) appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions; (3) proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly. In May 1978, the Committee report was submitted by the Secretary to two Congressional Committees: the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives.

How to order:
National Institute of Mental Health
National Clearinghouse for Mental Health Information
Public Inquiries Section, Room 11A–21
5600 Fishers Lane, Rockville, Md. 20857

Report to the President
The President's Commission on Mental Health

The Commission was established by Executive Order, signed by President Carter February 17, 1977, to review the mental health needs of the Nation and to make recommendations to the President as to how the Nation might best meet these needs.

The Report to the President from the President's Commission on Mental Health consists of four volumes. Volume I is the Commission's Report and Recommendations to the President. Volumes II, III, and IV are Appendixes to the Report. These contain the reports of task panels comprised of about 450 individuals from throughout the country, who volunteered their expertise with respect to the Nation's mental health needs and resources in specific categories. Although the Commission has adopted certain of the options proposed by the task panels, the opinions and recommendations contained in the three panel reports should be viewed as those of the panel members; they do not necessarily reflect the views of the Commission. Volume III contains a section on mental health of the elderly (pp. 1117–1154).

How to order:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Price: Volume I, Stock No. 040-000-00390-8, $2.75
Volume III, Stock No. 040-000-00392-4, $8.75

Public Policy and the Frail Elderly—A Staff Report
DHEW Office of Human Development Services, Federal Council on Aging

A priority concern of the Federal Council on Aging has been the problem of the oldest of the aged population whom it identifies as the "frail elderly." This target group consists of persons usually, but not always, over the age of 75, who because of the accumulation of various continuing problems often require one or several supportive services in order to cope with daily life. They are expected to become a sizable proportion of this country's population before the end of this century.

This report sets forth the "core services" for the frail elderly recommended by the Federal Council on Aging, and the principles on which these recommendations are based. It provides background on the process of development of the recommendations and action by other government and nongovernment organizations. The report also contains an excellent section on the demographic characteristics of the frail elderly.

How to order:

U.S. Department of Health and Human Services
Office of Human Development Services
Federal Council on Aging
Washington, D.C. 20201

DHEW Publication No. (OHDS) 79-20959

APPENDIX B. SELECTED DHHS REGIONAL OFFICE STAFF

May 1980

Region I—Boston
John F. Kennedy Federal Building
Boston, Mass. 02203
Office Hours: 8:30–5:00
Area Code—617

		FTS Number
Principal Regional Official	Mr. John F. Bean, Jr.	(8) 223-6831
Dir., Intergovernmental and Congressional Affairs	Mr. Kevin Boyle	(8) 223-6830
Regional Health Administrator	Mr. Edward J. Montminy	(8) 223-6827
Deputy Regional Health Administrator	Joseph F. Piffat, M.D.	(8) 223-6863
Dir., Office of Grants Management, PHS	Ms. Mary O'Brien	(8) 223-4411
Dir., Div. of Health Services Delivery	Louise Liang, M.D.	(8) 223-6898
Director, Div. of ADAMH Programs	T. Leon Nicks, Ph.D.	(8) 223-6411
Associate Director, Mental Health Unit	Stuart P. Howell, Ed.D.	(8) 223-4256
Associate Director, Special Programs Unit		
1. *Program Assignments*		
Regional Consultant for Alcoholism	Ms. Amy Barkin	
Regional Consultant for Drug Abuse	Mrs. Ernestine H. Kiano	
Additional Staff	Brian W. Flynn, Ed.D. Mrs. Martha Kvaal Mr. William Hudspeth Ms. Nancy MacGillvray	

2. *State Assignments*

Connecticut	Howell
Maine	Nicks (Temporary)
Massachusetts	Nicks
New Hampshire	Flynn
Rhode Island	Hudspeth
Vermont	Barkin

May 1980

Region II—New York

26 Federal Plaza
New York, New York 10007
Office Hours: 8:30–5:00
Area Code—212

		FTS Number
Acting Principal Regional Official	Mr. John F. Devine	(8) 264-4600
Dir., Intergovernmental and Congressional Affairs	Ms. Anne Perkins	(8) 264-4602
Regional Health Administrator	Mr. Karst J. Besteman	(8) 264-2561
Deputy Regional Health Administrator	C. Robert Dean, M.D.	(8) 264-2562
Dir., Office of Grants Management, PHS	Mr. Raymond Vacca	(8) 264-4493
Director, Div. of ADAMH Programs	Mrs. Jessie P. Dowling	(8) 264-2567

1. *Program Assignments*
   Substance Abuse and Mental Health

States Unit Chief, New Jersey and Virgin Islands	Mr. Ronald Moss
States Unit Chief, New York and Puerto Rico	Mr. Thomas Butler
Additional Staff	Mr. Norman Lebovits Mrs. Helen Stanford Mr. Robert Havlena Mrs. Lenore Sirner

2. *State Assignments*

New Jersey	Moss	(8) 264-2568
New York	Butler	(8) 264-2569
Puerto Rico	Butler	(8) 264-2570
Virgin Islands	Moss	
(New York City)	Lebovits	(8) 264-2570

May 1980

Region III—Philadelphia
Post Office Box 13716
Philadelphia, Pennsylvania 19101
Location: 3531-35 Market Street
(Visits only—11th Floor)
Office Hours: 8:30–5:00
(Flexi-tour starting at 7:30 a.m.)
Area Code—215

		FTS Number
Principal Regional Official	Mr. James Melody	(8) 596-6492
Dir., Intergovernmental and Congressional Affairs	Mr. Gregory L. Coleman	(8) 596-6492
Regional Health Administrator	H. MacDonald Rimple, M.D.	(8) 596-6637
Deputy Regional Health Administrator	Mr. O. Eugene Trivits	(8) 596-6638
Director, Office of Grants Management, PHS	Mr. Fred Gill	(8) 596-6653
Director, Div. of Health Services Delivery	Richard Sanders, Ph.D.	(8) 596-6122
Dep., Dir., Div. of Health Services Delivery	Mr. John LaFrance	(8) 596-1812
Director, Div. of ADAMH Programs	Mr. Finbarr M. O'Connell	(8) 596-6678/9
1. *Program Assignments*		
Chief, Mental Health Cluster	Mr. Anson B. Haughton	(8) 596-1847

Additional Staff	Ms. Gayle Auchenbach	(8) 596-6619
	Howard Kroll, Ph.D.	(8) 596-1841
	Walter L. Lauterbach, Ph.D.	(8) 596-1853
	Ms. Martha Noyes-Stein	(8) 596-1855
	Ms. Trudy Persky	(8) 596-1843
	Marc R. Rose, D.S.W.	(8) 596-1849
	Nathan E. Seldin, D.S.W.	(8) 596-1839
	Mr. Peter Vaslow	(8) 596-1845
	John Wells, D.S.W.	(8) 596-1851
Regional Consultant for Alcoholism	Mr. Emory Johnson	(8) 596-1837
Regional Consultant for Drug Abuse	Mr. Emory Johnson	(8) 596-1837

2. *State Assignments*

Delaware	Rose
District of Columbia	Seldin
Maryland	Kroll
Pennsylvania	
Central	Persky
Eastern	Auchenbach
Northeastern	Lauterbach (Coordinator)
Western	Rose
Virginia	Wells
West Virginia	Vaslow

May 1980

Region IV—Atlanta
101 Marietta Tower
Atlanta, Georgia 30323
Office Hours: 8:00–4:30
Area Code—404

		FTS Number
Principal Regional Official	Ms. Sara V. Craig	(8) 242-2442

Director, Intergovernmental & Congressional Affairs	Mr. Ernest E. Moore, Jr.	(8) 242-2277
Regional Health Administrator	G. A. Reich, M.D., M.P.H.	(8) 242-2317
Deputy Regional Health Administrator	James T. Lovett, D.M.D.	(8) 242-2317
Executive Officer, PHS ...	Mr. William B. Lyons	(8) 242-5917
Acting Director, Office of Grants Management, PHS	Mr. William B. Lyons	(8) 242-5917
Director, Division of Health Services Delivery	Stephen H. King, M.D.	(8) 242-5655
Deputy Director, Division of Health Services Delivery	Mr. Joseph E. Coon	(8) 242-5655
Director, Division of ADAMH Programs	Mr. William D. Wright	(8) 242-2000
Deputy Director, Division of ADAMH Programs	Mr. Robert W. Carrick	(8) 242-2000
Program Assignments		
Branch Chief, GA/KY .	Beaumont R. Hagebak, Ed.D.	
	Mr. William I. Ivey	(8) 242-2000
Branch Chief, FL/MS ..	Mr. Douglas G. Greenwell	(8) 242-2000
	Nelms B. Boone, Ph.D.	(8) 242-2000
	Mrs. Joyce A. Wheeler	(8) 242-2000
Branch Chief, A1/TN ...	Mr. Samuel Stevenson	(8) 242-2000
	Mr. Bascom W. Carlton	(8) 242-2000
	Ms. M. Jane Yates, R.N.	(8) 242-2000
Branch Chief, NC/SC ..	Robert B. Dick, Ph.D.	(8) 242-2000
	Mr. Rafael A. Lago	(8) 242-2000

May 1980

Region V—Chicago
300 South Wacker Drive
Chicago, Illinois 60606
Office Hours: 8:15–4:45
Area Code—312

		FTS Number
Principal Regional Official	Mr. Christopher Cohen	(8) 353-5160
Dir., Intergovernmental and Congressional Affairs	Mr. Wilbur Schmidt	(8) 353-5677
Regional Health Administrator	E. Frank Ellis, M.D.	(8) 353-1385
Deputy Regional Health Administrator	Miss Julia C. Attwood	(8)353-1385
Dir., Office of Grants Management, PHS	Miss Catherine T. Bartley	(8) 353-8700
Dir., Div. of Health Services Delivery	Mr. Cayetano Santiago	(8) 353-1710
Dep. Dir., Div. of Health Services Delivery	Mr. Milt Schultz	(8) 353-4613
Director, Div. of ADAMH Programs	Mr. Michael F. Houlihan	(8) 886-3867
Dep. Dir., Div. of ADAMH Programs	John N. Krzemien, Ph.D.	(8) 353-7072
1. *Program Assignments*		
Chief, Mental Health Cluster	Ralph J. Melda, Ph.D.	(8) 886-3869
Chief, Program Development and Substance Abuse Cluster	Kenneth S. Watanabe, ACSW	(8) 886-3864
Additional Staff	Ms. Patricia Canan	(8) 886-3864
	Mr. Charles R. Dickey	(8) 886-2397
	Ms. Rita Fielder	(8) 886-5179
	Mr. Richard C. Kreisl	(8) 886-3872
	Mr. Robert Ray	(8) 886-3874
	Ms. Olinda Gonzalez	(8) 886-3870

2. *State Assignments*

Illinois	Love/LeClair
Michigan	Canan
Indiana	Kreisl
Ohio	Fielder
Wisconsin	Love
Minnesota	LeClair

May 1980

Region VI—Dallas
1200 Main Tower Building—Room 1800
Dallas, Texas 75202
Office Hours: 8:00–4:30
Area Code—214

		FTS Number
Principal Regional Official	Mr. Ben Jeffers	(8) 729-3301
Acting Dir., Intergovernmental and Congressional Affairs	Mr. William Crawford	(8) 729-3338
Acting Regional Health Administrator	Hilary Connor, M.D.	(8) 729-3879
Deputy Regional Health Administrator	C.F. Hamilton, M.D.	(8) 729-3879
Dir., Office of Grants Management, PHS	Mr. Robert J. Winston	(8) 729-3885
Dir., Div. of Health Services Delivery	Ms. Kathryn M. Fritz	(8) 729-3041
Dep. Director of Health Services Delivery	Gordon Green, M.D.	(8) 729-3041
Director, Division of ADAMH Programs	Ernest C. Land, Ph.D.	(8) 729-3081

1. *Program Assignments*

Regional Consultant for Alcoholism	Everett N. Pile, Ph.D.
Regional Consultant for Drug Abuse	Mr. Samuel N. Brito
Regional Consultant for Mental Health	Mr. Phillip W. Edgington

Additional Staff	Ms. Ann Eades Mr. James D. Ebner Mr. Kenneth Grace Mr. Hector Sanchez Mrs. Marian Stone Vacancy

2. *State Assignments*

Arkansas	Sanchez
Louisiana	Pile
New Mexico	Edgington
Oklahoma	Eades
Texas	Brito

For commercial calls use *767*

May 1980

Region VII—Kansas City
601 E. 12th Street
Kansas City, Missouri 64106
Office Hours: 8:00–4:30
Area Code—816

		FTS Number
Principal Regional Official (Acting)	Mr. James Bergfalk	(8) 758-2821
Dir., Intergovernmental and Congressional Affairs	Mr. James Bergfalk	(8) 758-2821
Regional Health Administrator	Mr. Y.B. Rhee	(8) 758-3291
Deputy Regional Health Administrator	William B. Hope, Jr., Sc.D.	(8) 758-3293
Executive Officer	Ms. Carole Edison	(8) 758-3491
Dir., Office of Grants Management, PHS	Mr. Dean Chocholousek	(8) 758-5841
Director, Div. of ADAMH Programs	Stephanie B. Stolz, Ph.D.	(8) 758-5291

1. *Program Assignments*

RPC for Alcoholism Services	Mr. C. Ellis Barham
RPC for Minority Mental Health Matters	Mr. Morris J. Smith

RPC for Rural Mental Health	Mr. C. Ellis Barham
RPC for 2% Technical Assistance	Robert R. Waggener, Ph.D.
RPC for Elderly	Mr. William G. Mayfield
RPC for Drug Abuse Services	Mr. Morris J. Smith
Additional Staff:	
Program Assistant	Ms. B. Ellen Phipps
TA Program Specialist	Ms. Helen L. Weller
NHIP Consultant	Mr. Robert D. Ray
Program Assistant	Ms. Virginia Gross

2. *State Assignments*

Iowa	Mr. Smith
Kansas	Team Leader: Dr. Waggener
Missouri	Team Leader: Mr. Mayfield
Nebraska	Mr. Barham

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May 1980

Region VIII—Denver
Federal Office Building
1961 Stout Street
Denver, Colorado 80202
Office Hours: 8:00–4:30
Area Code—303

		FTS Number
Principal Regional Official	Mr. Wellington E. Webb	(8) 327-3373
Dir., Intergovernmental & Congressional Affairs	Ms. Grace Mickelson	(8) 327-3373
Regional Health Administrator	Hilary H. Connor, M.D.	(8) 327-4461
Deputy Regional Health Administrator	Abel Garcia Ossorio, Ph.D.	(8) 327-4461
Dir., Office of Grants Management, PHS	Mr. William J. Lang, Acting	(8) 327-4463
Director, Div. of ADAMH Programs	Stanley C. Mahoney, Ph.D.	(8) 327-2555

Dep. Dir., Div. of ADAMH Programs	Mr. Ernest D. Ficco	(8) 327-2555

1. *Program Assignments*

Alcoholism and Alcohol Abuse Coordinator	Mr. John E. Holman
Drug Abuse Coordinator	Mr. Ernest D. Ficco
Mental Health Coordinator	Stanley C. Mahoney, Ph.D.
Additional Staff	A. Roland Garcia, Ph.D. Ernest Hamburger, M.D. Mr. Henry James, MSW Miss A. Naomi Kennedy, R.N. Mrs. Grace Patston Mr. Ignacio Rodriguez, Jr. Ms. Barbara Talbot Hugh S. Sloan, Jr., DSW

2. *State Assignments*

Colorado	Ficco
Montana	Kennedy
North Dakota	Sloan
South Dakota	Rodriguez
Utah	Holman
Wyoming	Garcia

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May 1980

Region IX—San Francisco

Federal Office Building
50 United Nations Plaza, Room 322
San Francisco, California 94102
Office Hours: 8:00–4:30
Area Code—415.

		FTS Number
Principal Regional Official	Mr. Michael W. Murray	(8) 556-6746
Dir., Intergovernmental and Congressional Affairs	Ms. Gloria Molina	(8) 556-6603

Regional Health Administrator	Sheridan L. Weinstein, M.D.	(8) 556-5810
Deputy Regional Health Administrator	Kent Angerbauer, D.D.S.	(8) 556-2883
Dir., Office of Grants Management, PHS	Allan Harris	(8) 556-3586
Director, Div. of ADAMH Programs	Ms. Dorine Loso	(8) 556-2215
1. *Program Assignments*		
Chief, Substance Abuse and Special Programs	Mr. Roberto Duron	
Additional Staff:		
Psychiatric Consultant	James M. Jaranson, M.D.	
RPC for Community Support Programs	Mr. Joseph Rowell	
RPC for Long-Term Care	Mrs. Jesna P. Swan	
RPC for Drug Abuse and Alcohol	Mr. Carlos F. Reyna	
Chief, Mental Health Services Delivery	Mr. Joseph H. Hoffman	
Additional Staff:		
Mental Health Consultant	Mr. Edgar Gallardo	
Mental Health Consultant	Miss Alice Harmon	
Mental Health Consultant	Mrs. Etoile Holmes	
Mental Health Consultant	Reiko Homma-True, Ph.D.	
Mental Health Consultant	Mr. Thomas Uridel	
Mental Health Consultant	Mr. Larry J. Wong	
Program Assistant	Ms. Maryanne Malone	
2. *State Assignments*		
Arizona	True	
California		
Northern	Harmon	
Los Angeles County	Uridel	
Rest of State	Holmes	

Hawaii	Wong
Nevada	Holmes
Pacific Basin	Wong

May 1980

Region X—Seattle
Arcade Plaza
1321 Second Avenue, MS 825
Seattle, Washington 98101
Office Hours: 8:00–4:30
Area Code—206

		FTS Number
Principal Regional Official	Mr. Bernard E. Kelly	(8) 399-0420
Dir., Intergovernmental and Congressional Affairs	Mr. Robert A. Merlino	(8) 399-1290
Regional Health Administrator	Ms. Dorothy H. Mann	(8) 399-0430
Deputy Regional Health Administrator	Mr. Michael R. Street	(8) 399-0432
Director, Office of Grants Management, PHS	Ms. Patricia Walker	(8) 399-7997
Director, Div. of ADAMH Programs	Mr. Jack Bartleson	(8) 399-0524

1. *Program Assignments*

Program Consultant for Substance Abuse	Ms. Hazel Walter
Program Consultant for Mental Health	Ms. Norma Baxter
Additional Staff	Mr. David J. Rokosky Willard W. Mollerstrom, Ph.D.

2. *State Assignments*

Alaska and King County (Washington)	Mollerstrom
Idaho	Mollerstrom
Oregon	Rokosky
Washington (excluding King County)	Baxter

For commercial calls use *442*

APPENDIX C.
STATE MENTAL HEALTH AUTHORITIES

Officially Designated Authority	*Program Contact*
1. ALABAMA	
State Department of Mental Health Mr. Glenn Ireland, II Commissioner 135 South Union Street Montgomery, Alabama 36130 Tel. (205) 834-4350	Same as Authority
2. ALASKA	
Alaska Dept. of Health and Social Services Helen A. Beirne, Ph.D. Commissioner Pouch H-01 Juneau, Alaska 99811 Tel. (907) 465-3030	Verner Stillner, M.D., M.P.H. Director Division of Mental Health and Developmental Disabilities Alaska Dept. of Health and Social Services Pouch H-04 Juneau, Alaska 99811 Tel. (907) 465-3370
3. ARIZONA	
Arizona Dept. of Health Services Suzanne Dandoy, M.D., M.P.H. Director 1740 West Adams Street Phoenix, Arizona 85007 Tel. (602) 255-1024	Mr. Jack Beveridge, Acting Chief Bureau of Community Services Div. of Behavioral Health Services Arizona Dept. of Health Services 2500 East Van Buren Phoenix, Arizona 85008 Tel. (602) 255-1231/2

4. ARKANSAS

* Arkansas State Hospital
* Div. of Mental Health Services
Mr. Patrick Hamilton
Acting Commissioner Mental Health Services
4313 West Markham Street
Little Rock, Arkansas 72201

Tel. (501) 664-4500 X401

Larry R. Faulkner, M.D.
Deputy Commissioner for Community Mental Health Services and Affiliated Programs
Div. of Mental Health Services
Dept. of Human Services
4313 West Markham Street
Little Rock, Arkansas 72201

Tel. (501) 664-4500 X381

5. CALIFORNIA

** California Dept. of Mental Health
Dale H. Farabee, M.D.
Director
2260 Park Towne Circle
Sacramento, California 95826

Tel. (916) 920-6712

Same as Authority

6. COLORADO

Colorado Dept. of Institutions
Raymond Leidig, M.D.
Executive Director
3550 West Oxford Avenue
Denver, Colorado 80236

Tel. (303) 761-0220 X225

Sutherland Miller, Ph.D.
Director
Division of Mental Health
Colorado Dept. of Institutions
3520 West Oxford Avenue
Denver, Colorado 80236

Tel. (303) 761-0220 X201

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* Arkansas State Hospital and the Division of Mental Health Services are under the Department of Human Services.

** The Department of Mental Health and the Department of Alcohol and Drug Programs are under the *California Health and Welfare Agency*.

7. CONNECTICUT

Connecticut Dept. of Mental Health
Eric A. Plaut, M.D.
Commissioner
90 Washington Street
Hartford, Connecticut 06115

Tel. (203) 566-3650

Same as Authority

8. DELAWARE

Dept. of Health & Social Services
Mrs. Patricia C. Schramm
Secretary
Administration Bldg., 3rd floor
Delaware State Hospital
New Castle, Delaware 19720

Tel. (302) 421-6705

Mr. Sheldon Schweidel
Director
Division of Mental Health
Delaware State Hospital
C. T. Building
New Castle, Delaware 19720

Tel. (302) 421-6101

9. DISTRICT OF COLUMBIA

Department of Human Resources
Mr. Albert P. Russo
Director
District Building
1350 E Street, N.W.
Washington, D.C. 20004

Tel. (202) 727-0310

Evelyn Ireland, Ph.D.
Acting Administrator
Mental Health Administration
Department of Human Resources
1875 Connecticut Avenue, N.W.
Washington, D.C. 20009

Tel. (202) 673-6720

10. FLORIDA

Florida Dept. of Health and Rehabilitative Services
Mr. Abe Lavine
Assistant Secretary for Program Planning and Development
1323 Winewood Boulevard
Tallahassee, Florida 32301

Tel. (904) 487-1111

Robert R. Furlough, Ph.D.
Acting Mental Health Program Staff Director
Mental Health Program Office
1323 Winewood Boulevard
Tallahassee, Florida 32301

Tel. (904) 488-8304

11. GEORGIA

Department of Human Resources
W. Douglas Skelton, M.D.
Commissioner
47 Trinity Avenue, S.W.
State Office Bldg., Room 620
Atlanta, Georgia 30334

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Mr. R. Derril Gay
Director
Div. of Mental Health and Mental Retardation
Department of Human Resources
47 Trinity Avenue, S.W.
Health Building, Room 315-H
Atlanta, Georgia 30334

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12. HAWAII

State Department of Health
Mr. George A. L. Yuen
Director
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Honolulu, Hawaii 96801

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Denis Mee-Lee, M.D.
Chief
Mental Health Division
State Department of Health
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Tel. (808) 548-6335

13. IDAHO

Dept. of Health and Welfare Mr. Milton Klein Director 700 W. State STATEHOUSE Mail Boise, Idaho 83720 Tel. (208) 334-2336	Dr. Robert W. Glover Administrator Div. of Community Rehabilitation Dept. of Health and Welfare 700 W. State STATEHOUSE Mail Boise, Idaho 83720 Tel. (208) 334-4000

14. ILLINOIS

Illinois Dept. of Mental Health and Developmental Disabilities Robert A. deVito, M.D. Director 160 N. LaSalle Street Room 1500 Chicago, Illinois 60601 Tel. (312) 793-2730	Same as Authority

15. INDIANA

Indiana Dept. of Mental Health Dr. William E. Murray Commissioner 5 Indiana Square Indianapolis, Indiana 46204 Tel. (317) 232-7844	Same as Authority

16. IOWA

Iowa Mental Health
Authority
Dr. Herbert L. Nelson
Director
Oakdale Campus
Oakdale, Iowa 52319

Tel. (319) 353-3901

RE: 314(d) State Mental
Health Plan, Community
Mental Health Authority

Same as Authority

Department of Social Services
Div. of Mental Health
Resources
Mr. Charles M. Palmer
Director
Hoover State Office Building
Des Moines, Iowa 50319

Tel. (515) 281-6003

RE: State Hospital Authority

Same as Authority

17. KANSAS

State Dept. of Social and
Rehabilitation Services
Dr. Robert C. Harder
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State Office Building
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Mr. Ken Keller
Acting Director
Div. of Mental Health and
Retardation Services
State Dept. of Social and
Rehabilitation Services
State Office Building
Topeka, Kansas 66612

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18. KENTUCKY

Department for Human Resources
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Secretary
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Frankfort, Kentucky 40621

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Mrs. Verna Fairchild, R.N.
Acting Director
Div. for Mental Health
Bureau for Health Services
Department for Human Resources
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19. LOUISIANA

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Carolyn T. Kitchin, M.D.
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Office of Mental Health and Substance Abuse
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20. MAINE

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Mrs. Chase Whittenberger
Director
Bureau of Mental Health
Maine Department of Mental Health and Corrections
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21. MARYLAND

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Mental Hygiene Administration
Maryland Department of Health and Mental Hygiene
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201 W. Preston St., 4th floor
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22. MASSACHUSETTS

Massachusetts Dept. of Mental Health
Robert L. Okin, M.D.
Commissioner
160 North Washington Street
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Same as Authority

23. MICHIGAN

Michigan Dept. of Mental Health
Frank M. Ochberg, M.D.
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Lansing, Michigan 48926

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Same as Authority

24. MINNESOTA

Department of Public Welfare
Mental Health Bureau
Mr. Harvey Caldwell
Assistant Commissioner
Centennial Office Building
St. Paul, Minnesota 55155

Tel. (612) 296-2791

Mr. James (Terry) Sarazin
Director
Mental Illness Program
Division
Department of Public Welfare
Centennial Office Building
St. Paul, Minnesota 55155

Tel. (612) 296-2710

25. MISSISSIPPI

State Dept. of Mental Health
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Executive Director
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Jackson, Mississippi 39201

Tel. (601) 354-6132

A. G. Anderson, M.D.
Director
Division of Mental Health
State Dept. of Mental Health
607 Robert E. Lee Office Bldg.
Jackson, Mississippi 39201

Tel. (601) 354-7041

26. MISSOURI

Department of Mental Health
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Nancy Barron, Ph.D.
Program Evaluation and
Planning Coordinator
Department of Mental Health
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27. MONTANA

Montana State Dept. of Institutions
Mr. Lawrence M. Zanto
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Tel. (406) 449-3930

Dr. Peter S. Blouke
Administrator
Mental Health and Residential Services Division
Montana State Department of Institutions
1539 11th Avenue
Helena, Montana 59601

Tel. (406) 449-3964

28. NEBRASKA

State Department of Public Institutions
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Tel. (402) 471-2851

Charles W. Landgraf, Jr., M.D.
Acting Director
Division of Medical Services
State Department of Public Institutions
Post Office Box 94728
Lincoln, Nebraska 68509

Tel. (402) 471-2851

29. NEVADA

Department of Human Resources
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State Capitol Complex
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Tel. (702) 885-4730

Mr. Jerome Griepentrog
Administrator
Division of Mental Hygiene/Mental Retardation
1937 North Carson St. Suite 244
Carson City, Nevada 89701

Tel. (702) 885-5943

30. NEW HAMPSHIRE

Department of Health and Welfare
Mr. Edgar J. Helms
Commissioner
Hazen Drive
Concord, New Hampshire 03301

Tel. (603) 271-4331

Gary E. Miller, M.D.
Director
Division of Mental Health
Hazen Drive
Concord, New Hampshire 03301

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31. NEW JERSEY

New Jersey State Department of Human Services
Ann Klein
Commissioner
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Trenton, New Jersey 08625

Tel. (609) 292-3717

Michail Rotov, M.D.
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Capital Place One
222 South Warren Street
Trenton, New Jersey 08625

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32. NEW MEXICO

New Mexico Department of Health and Environment
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Secretary
Post Offiice Box 968
Santa Fe, New Mexico 87503

Tel. (505) 827-5671, x200

Marshall Fitz, M.D.
Chief, Mental Health Bureau
* Divison of Behavioral Health Services
New Mexico Department of Health and Environment
Post Office Box 968
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Tel. (505) 827-5271

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* Dr. Scott H. Nelson is Director of the Division of Behavioral Health Services, which includes mental health, alcoholism, and drug abuse programs.

33. NEW YORK

Office of Mental Health
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Donald G. Miles, Ed.D.
Deputy Commissioner
Division of Program Operations
Office of Mental Health
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Tel. (518) 474-6567

34. NORTH CAROLINA

North Carolina Department of Human Resources
Sarah T. Morrow, M.D., M.P.H.
Secretary
325 N. Salisbury Street
Raleigh, North Carolina 27611

Tel. (919) 733-4534

Mr. Ben W. Aiken
Director
Divison of Mental Health and Mental Retardation Services
North Carolina Department of Human Resources
325 N. Salisbury Street
Raleigh, North Carolina 27611

Tel. (919) 733-7011

35. NORTH DAKOTA

State Department of Health
North Dakota Division of Mental Health and Retardation
Mr. Samih A. Ismir
Acting Director
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Mr. Samih A. Ismir
Assistant Director
Mental Health and Retardation Services
North Dakota Division of Mental Health and Retardation
State Department of Health
909 Basin Avenue
Bismarck, North Dakota 58505

Tel. (701) 224-2766

36. OHIO

Ohio Department of Mental Health and Mental Retardation
Timothy B. Moritz, M.D.
Director
30 E. Broad Street
Room 1182
Columbus, Ohio 43215

Tel. (614) 466-2337

Same as Authority

37. OKLAHOMA

State Department of Mental Health
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Director
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Capitol Station
Oklahoma City, Oklahoma 73152

Tel. (405) 521-2811

Mr. John H. Holt
Deputy Director for Hospital Services
State Department of Mental Health
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Oklahoma City, Oklahoma 73152

Tel. (405) 521-2811

38. OREGON

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Assistant Director, Human Resources and Administration of Mental Health
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* The Mental Health Division is in the Department of Human Resources, which is headed by Mr. Leo T. Hegstrom, 318 Public Service Bldg., Salem, Oregon 97310.

39. PENNSYLVANIA

State Department of Public Welfare
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Secretary of Welfare
Health and Welfare Bldg., Room 333
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Mr. Robert P. Haigh
Acting Deputy Secretary for Mental Health
State Dept. of Public Welfare
Health and Welfare Bldg. Rm. 308
Harrisburg, Pennsylvania 17120

Tel. (717) 787-6443

40. RHODE ISLAND

Rhode Island Dept. of Mental Health Retardation, and Hospitals
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Tel. (401) 464-3201

Mr. Neil Meisler, Administrator
Mental Health
Office of Community Mental Health Service
Rhode Island Dept. of Mental Health, Retardation, and Hospitals
Rhode Island Medical Center
Cottage #403
Cranston, Rhode Island 02920

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41. SOUTH CAROLINA

State Department of Mental Health
Dr. William S. Hall
Commissioner
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42. SOUTH DAKOTA

State Dept. of Social Services
Office of Mental Health
Mr. Mike Adamski
Acting Program
Administrator
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Same as Authority

43. TENNESSEE

Tennessee Dept. of Mental
Health and Mental
Retardation
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Robert Fink, M.D.
Acting Assistant
Commissioner
Division of Mental Health
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Tennessee Dept. of Mental
Health and Mental
Retardation
501 Union Bldg., lower level
Nashville, Tennessee 37219

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44. TEXAS

Texas Dept. of Mental Health
and Mental Retardation
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Post Office Box 12668
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Jon D. Hannum, Ph.D.
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Community Services
Texas Dept. of Mental Health
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45. UTAH

State Dept. of Social Services
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Executive Director
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Wilfred H. Higashi, Ph.D.
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Division of Mental Health
Utah Dept. of Social Services
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46. VERMONT

* Vermont Dept. of Mental Health
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Same as Authority

47. VIRGINIA

State Dept. of Mental Health and Mental Retardation
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Miss Margaret L. Cavey, R.N.
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Division of Mental Health
State Dept. of Mental Health and Mental Retardation
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Richmond, Virginia 23214

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---

* Both the Department of Mental Health and the Department of Social and Rehabilitation Services are under the Agency of Human Services, headed by Sister Elizabeth Candon.

48. WASHINGTON

* Mental Health Division
Delbert M. Kole, M.D.
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Same as Authority

49. WEST VIRGINIA

Office of Community Health Services**
Mel Henry, Ph.D.
Director
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Mr. Randy Myers
Acting Director
Division of Behavioral Health Services
Office of Community Health Services**
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50. WISCONSIN

Wisconsin Department of Health and Social Services
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Secretary
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Mr. Burton A. Wagner
Administrator
Division of Community Services
Wisconsin Department of Health and Social Services
State Office Bldg., Room 534
1 West Wilson Street
Madison, Wisconsin 53702

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---

* Both the Mental Health Division and the Bureau of Alcohol and Substance Abuse are under the Department of Social and Health Services.

** The Office of Community Health Services is under the State Department of Health.

51. WYOMING

*Division of Community Programs
Mr. Guy Noe
Administrator
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Cheyenne, Wyoming 82002

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Same as Authority

52. AMERICAN SAMOA

Government of American Samoa
Department of Medical Services
Julia Grach, M.D.
Director
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American Samoa 96799

Tel. Overseas Operator and 633-5732

Guy Spinello, M.D.
Director
Mental Health Clinic
LBJ Tropical Medical Center
Pago Pago, Tutuila
American Samoa 96799

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53. GUAM

Government of Guam
Mental Health and Substance Abuse Agency
Mr. Peter A. San Nicolas
Administrator
Post Office Box 20999, Main Facility
Guam 96921
Tel. Overseas Operator and 477-9704/5

Same as Authority

---

* The Division of Community Programs is under the Department of Health and Social Services.

54. NORTHERN MARIANA ISLANDS

Commonwealth of the
Northern Mariana Islands
Division of Mental Health
Dr. Frances Schwaninger-Morse
Dr. Torres Hospital
Saipan, Mariana Islands
96950

Tel. Overseas Operator and
6110 or 9314

Same as Authority

55. PUERTO RICO

Department of Health
Dr. Jaime Rivera Dueno
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Santurce, Puerto Rico 00908

Tel. (809) 765-7453

Dr. Aida Guzman
Assistant Secretary for
Mental Health
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San Juan, Puerto Rico 00936

Tel. (809) 781-5660

56. TRUST TERRITORY

Office of the High
Commissioner
Masao Kumangai
Medical Officer, M.P.H.
Director of Health Services
Trust Territory of the Pacific
Islands
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96950

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Paul W. Dale, M.D.
Chief
Mental Health Branch
Bureau of Health Services
Office of the High
Commissioner
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96950

Tel. Overseas Operator
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57. VIRGIN ISLANDS

Government of the Virgin Islands
Virgin Islands Department of Health
Roy L. Schneider, M.D.
Commissioner of Health
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Chester D. Copemann, Ph.D.
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APPENDIX D. STATE AGENCIES ON AGING

ALABAMA

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ALASKA

M.D. Plotnick
Coordinator
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Department of Health and Social Services
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ARKANSAS

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Director
Office on Aging and Adult Services
Department of Social and Rehabilitation Servs.
Donaghey Building, #1031S
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CALIFORNIA

Janet J. Levy
Director
Department of Aging
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COLORADO

Dorothy Anders
Director
Division of Services for the Aging
Department of Social Servs.
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CONNECTICUT

Marin Shealy
Commissioner
Department on Aging
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DELAWARE

Eleanor Cain
Director
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Department of Health and Social Services
Newcastle, Delaware 19720
(302) 421-6791

KENTUCKY

Fannie Dorsey
Director
Center for Aging Services
Bureau of Social Services
Human Service Building, 6th Floor
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Frankfort, Kentucky 40601
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LOUISIANA

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MAINE

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Community Services Unit
Department of Human Services
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MARYLAND

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MASSACHUSETTS

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MISSOURI

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Director
Division on Aging
Department of Social Services
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MONTANA

Holly Luck
Director
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Department of Social and Rehabilitation Services
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Helena, Montana 59601
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OREGON

Robert Zeigen, Director
Office of Elderly Affairs
Human Resources Department
772 Commercial Street, S.E.
Salem, Oregon 97310
(503) 378-4728

PENNSYLVANIA

Gorham L. Black, Jr.
Secretary of Aging
Department of Aging
Room #307, Finance Bldg.
Harrisburg, Pennsylvania 17120
(717) 783-1550

PUERTO RICO

Alicia Ramirez Suarez
Executive Director
Gericulture Commission
Department of Social Services
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Santurce, Puerto Rico 00908
(809) 722-2429

RHODE ISLAND

Anna M. Tucker
Director
Department of Elderly Affairs
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Providence, Rhode Island 02903
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AMERICAN SAMOA

Tali T. Maae
Director
Territorial Aging Program
Government of American Samoa
Office of the Governor
Pago Pago, American Samoa 96799
Samo 3-1254 or 3-4116

SOUTH CAROLINA

Harry Bryan
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915 Main Street
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SOUTH DAKOTA

Sylvia Base
Acting Director
Office on Aging
Adult Services
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TENNESSEE

Tom G. Henry
Director
Commission on Aging
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Nashville, Tennessee 37219
(615) 741-2056

TEXAS

Ms. Chris Kyker
Director
Governor's Committee on Aging
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MARIANA ISLANDS

Lynn Peterson
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Office of Aging
Community Development Division
Government of the Trust Territory of the Pacific Islands
Saipan, Naruaba Uskabds 96950
Overseas Operator: 2143

UTAH

Leon PoVey
Director
Division of Aging
Department of Social Services
150 West North Temple
Box #2500
Salt Lake City, Utah 84102
(801) 533-6422

APPENDIX E. MEDICAID DIRECTORY

Single State Agencies and State Medical Assistance Units

- Alabama (region IV):
  - Single State agency and Medical assistance unit:
    - Medical Services Administration
      2500 Fairlane Drive
      Montgomery, Alabama 36130
      205/277-2710
- Alaska (region X):
  - Single State agency:
    - Department of Health and Social Services
      Pouch H-01
      Juneau, Alaska 99811
      907/465-3030
  - Medical assistance unit:
    - Division of Public Assistance
      Department of Health and Social Services
      Pouch H-07
      Juneau, Alaska 99811
      907/465-3355
- Arkansas (region VI):
  - Single State agency:
    - Department of Human Services
      406 National Old Line Building
      Little Rock, Arkansas 72201
      501/371-1001
  - Medical assistance unit:
    - Office of Medical Services
      Division of Social Services
      Dept. of Human Services
      P.O. Box 1437
      Little Rock, Arkansas 72203
      501/371-1806
- California (region IX):
  - Single State agency:
    - Department of Health
      714 P Street
      Office Building Number 8
      Sacramento, California 95814
      916/445-1248
  - Medical assistance unit:
    - Medical Assistance Division
      State Department of Health
      714 P Street
      Sacramento, California 95814
      916/322-2334
- Colorado (region VIII):
  - Single State agency:
    - Department of Social Services
      1575 Sherman Street
      Denver, Colorado 80203
      303/839-3513
  - Medical assistance unit:
    - Division of Medical Assistance
      Department of Social Services
      1575 Sherman Street
      Denver, Colorado 80203
      303/839-3031
- Connecticut (region I):
  - Single State agency:
    - Department of Social Services
      110 Bartholomew Avenue
      Hartford, Connecticut 06306
      203/566-2008
  - Medical assistance unit:
    - Medical Care Administration
      Department of Social Services
      110 Bartholomew Avenue
      Hartford, Connecticut 06306
      203/566-3435
- Delaware (region III):
  - Single State agency:
    - Department of Health and Social Services
      Delaware State Hospital
      New Castle, Delaware 19730
      302/421-6705
  - Medical assistance unit:
    - Medical Assistance Services
      Department of Health and Social Services
      P.O. Box 309
      Wilmington, Delaware 19899
      302/571-3130/3131
- District Of Columbia (region III):
  - Single State agency:
    - Department of Human Resources
      District Building–Room 406
      1350 E Street, NW
      Washington, D.C. 20004
      202/629-3079
  - Medical assistance unit:
    Department of Human Resources
    1329 E Street, NW
    Washington, D.C. 20004
    202/347-3512
- Florida (region IV):
  - Single State agency:
    - Department of Health and Rehabilitative Services
      1323 Winewood Blvd.

Tallahassee, Florida 32301
904/488-7721
Medical assistance unit:
Medical Services
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
904/487-2380

Georgia (region IV):
Single State agency:
Georgia Department of Medical Assistance
1010 West Peachtree St., NW
Atlanta, Georgia 30309
404/894-4911
Medical assistance unit:
Medicaid Office
Department of Medical Assistance
1010 West Peachtree Street, NW
Atlanta, Georgia 30309
404/894-4911

Guam (region IX):
Single State agency:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
Overseas Operator: 734-9901
Medical assistance unit:
Medical Care Services
Department of Public Health and Social Services
P.O. Box 2719
Agana, Guam 96910
Overseas Operator: 734-9901

Hawaii (region IX):
Single State agency:
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808/548-6260
Medical assistance unit:
Medical Care Administration
Department of Social Service and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808/548-6584

Idaho (region X):
Single State agency:
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208/384-2336
Medical assistance unit:
Bureau of Medical Assistance
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208/384-3556

Illinois (region V):
Single State agency:
Dept. of Public Aid
316 South Second Street
Springfield, Illinois 62706
217/782-6716
Medical assistance unit:
Division of Medical Program Services
316 South Second Street
Springfield, Illinois 62706
217/782-1211

Indiana (region V):
Single State agency:
Dept. of Public Welfare
State Office Building
100 North Senate Avenue–Room 701
Indianapolis, Indiana 46204
317/633-6650
Medical assistance unit:
Division of Medical Services
State Department of Public Welfare
100 North Senate Avenue
Room 701
Indianapolis, Indiana 46204
317/633-5582

Iowa (region VII):
Single State agency:
Department of Social Services
Lucas State Office Building
Des Moines, Iowa 50319
515/281-5452
Medical assistance unit:
Medical Services Section
Department of Social Services
Lucas State Office Building
Des Moines, Iowa 50319
515/281-3386

Kansas (region VII):
Single State agency:
Department of Social and Rehabilitation Service
State Office Building
Topeka, Kansas 66612
913/296-3271
Medical assistance unit:
Medical Services Section
Department of Social and Rehabilitation Service
State Office Building
Topeka, Kansas 66612
913/296-3981

Kentucky (region IV):
Single State agency:
Department for Human Resources
DHR Building
Frankfort, Kentucky 40601
502/564-7130
Medical assistance unit:
Division for Medical Assistance
Bureau for Social Insurance
Department for Human Resources
Frankfort, Kentucky 40601
502/564-4321

Louisiana (region VI):
Single State agency:
Health and Human Resources Administration
P.O. Box 44215
Baton Rouge, Louisiana 70804
504/389-5796
Medical assistance unit:
Medical Assistance Program
Office of Family Services
Medical Assistance Unit
P.O. Box 44065
Baton Rouge, Louisiana 70804
504/389-5035

Maine (region I):
Single State agency
Department of Human Services
Statehouse
Augusta, Maine 04330
207/289-2736
Medical assistance unit:
Medical Assistance Unit
Department of Human Services
Statehouse
Augusta, Maine 04330
207/289-3846

Maryland (region III):
Single State agency:
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301/383-2600
Medical assistance unit:
Medical Programs
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301/383-6327

Massachusetts (region I):
Single State agency:
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617/727-6190
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617/727-5580
Medical assistance unit:
Medical Assistance
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617/727-6095/3907
Medical Assistance
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617/727-5590

Michigan (region V):
Single State agency:
Michigan Department of Social Services
Commerce Center Building
300 South Capitol Avenue
Lansing, Michigan 48926
517/373-2000
Medical assistance unit:
Bureau of Medical Assistance
Department of Social Services
300 South Capitol Avenue
Lansing, Michigan 48926
517/373-1970

Minnesota (region V):
Single State agency:
Dept. of Public Welfare
Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
612/296-2701
Medical assistance unit:
Medical Assistance Program
Bureau of Income Maintenance
Department of Public Welfare
690 North Robert Street
Saint Paul, Minnesota 55155
612/296-8517

Mississippi (region IV):
Single State agency and Medical assistance unit:
Mississippi Medicaid Commission
Third Floor, Dale Building, North
2906 North State Street
P.O. Box 5160
Jackson, Mississippi 39216
601/354-7464

Missouri (region VII):
Single State agency:
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314/751-4247
Medical assistance unit:
Medical Services
Division of Family Services
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314/751-2500

Montana (region VIII):
Single State agency:
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406/449-3451
Medical assistance unit:
Medical Assistance Bureau
Economic Assistance Division
Department of Social and Rehabilitation Services
P.O. Box 4210

Helena, Montana 59601
406/449-3952

Nebraska (region VII):
Single State agency:
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402/471-3121
Medical assistance unit:
Medical Services Division
Department of Public Welfare
301 Centennial Mall South, 5th Floor
Lincoln, Nebraska 68509
402/471-3121

Nevada (region IX):
Single State agency:
Department of Human Resources
Kinkead Building–Capitol Complex
505 East King Street
Carson City, Nevada 89710
702/885-4730
Medical assistance unit:
Medical Care Section
Welfare Division
Department of Human Resources
251 Jeanell Drive
Capital Complex
Carson City, Nevada 89710
702/885-4775

New Hampshire (region I):
Single State agency:
Department of Health and Welfare Services
8 Loudon Road
Concord, New Hampshire 03301
603/271-3331
Medical assistance unit:
Office of Medical Services
8 Loudon Road
Concord, New Hampshire 03301
603/271-3706

New Jersey (region II):
Single State agency:
Department of Human Services
135 West Hanover
Trenton, New Jersey 08625
609/292-3713
Medical assistance unit:
Division of Medical Assistance and Health Services
Department of Human Services
324 East State Street
Trenton, New Jersey 08608
609/292-7110

New Mexico (region VI):
Single State agency:
Health and Social Services Department
P.O. Box 2348
Santa Fe, New Mexico 87503
505/827-2371
Medical assistance unit:
Medical Assistance Division
Health and Social Services Department
P.O. Box 2348
Santa Fe, New Mexico 87503
505/827-2401

New York (region II):
Single State agency:
State Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518/474-9475
Medical assistance unit:
Division of Medical Assistance
State Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518/474-9132

North Carolina (region IV):
Single State agency:
Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919/733-4534
Medical assistance unit:
Medical Services Section
Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919/733-2060

North Dakota (region VIII):
Single State agency:
Social Services Board of North Dakota
State Capitol Building
Bismarck, North Dakota 58505
701/224-2321
Medical assistance unit:
Medical Services
Social Services Board of North Dakota
State Capitol Building
Bismarck, North Dakota 58505
701/224-2321

Ohio (region V):
Single State agency:
Department of Public Welfare
30 East Broad Street, 32nd floor
Columbus, Ohio 43215
614/466-6282
Medical assistance unit:
Division of Medical Assistance
Department of Public Welfare
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215
614/466-2365

Oklahoma (region VI):
Single State agency:
Department of Institutions
Social and Rehabilitative Services

P.O. Box 25352
Oklahoma City, Oklahoma 73125
405/521-3646
Medical assistance unit:
Medical Services Division
Department of Institutions
Social and Rehabilitative Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405/521-3801
Oregon (region X):
Single State agency:
Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
503/378-3034
Medical assistance unit:
Adult and Family Services Division
Department of Human Resources
417 Public Service Building
Salem, Oregon 97310
503/378-3680
Pennsylvania (region III):
Single State agency:
State Department of Public Welfare
Health and Welfare Building
Harrisburg, Pennsylvania 17120
717/787-2600/3600
Medical assistance unit:
Bureau of Medical Assistance
State Department of Public Welfare
7th and Forester Streets
Harrisburg, Pennsylvania 17120
717/787-1170/1174
Puerto Rico (region II):
Single State agency:
Department of Health
P.O. Box 9342
Santurce, Puerto Rico 00908
809/723-2050
Medical assistance unit:
Health Economy Office
Department of Health
P.O. Box 10037
Caparra Heights Station
Rio Piedras, Puerto Rico 00922
809/765-9941
Rhode Island (region I):
Single State agency:
Department of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401/464-2121
Medical assistance unit:
Division of Medicaid Services
Department of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401/464-2174
South Carolina (region IV):
Single State agency:
State Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
803/758-3244
Medical assistance unit:
Division of Medical Assistance
State Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
803/758-2320
South Dakota (region VIII):
Single State agency:
Division of Social Welfare
Department of Social Services
State Office Building III
Illinois Street
Pierre, South Dakota 57501
605/224-3491
Medical assistance unit:
Office of Medical Services
Department of Social Services
State Office Building III
Pierre, South Dakota 57501
605/224-3495
Tennessee (region IV):
Single State agency:
Department of Public Health
344 Cordell Hull Building
Nashville, Tennessee 37219
615/741-3111
Medical assistance unit:
Bureau of Medicaid
Administration and Coordination
Department of Public Health
344 Cordell Hull Building
Nashville, Tennessee 37219
615/741-7894
Texas (region VI):
Single State agency:
Department of Human Resources
John H. Reagan Building
Austin, Texas 78701
512/475-5777
Medical assistance unit:
Department of Human Resources
John H. Reagan Building
Austin, Texas 78701
512/475-2541
Utah (region VIII):
Single State agency:
Department of Social Services
150 West North Temple
Salt Lake City, Utah 84110
801/533-5331
Medical assistance unit:
Office of Medical Services
Department of Social Services
150 West North Temple
Salt Lake City, Utah 84110
801/533-5038

Vermont (region I):
Single State agency:
Department of Social Welfare
State Office Building
Four East State Street
Montpelier, Vermont 05602
802/828-3421
Medical assistance unit:
Division of Medical Care
Department of Social Welfare
State Office Building
Four East State Street
Montpelier, Vermont 05602
802/828-3441
Virgin Islands (region II):
Single State agency:
Department of Health
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809/774-1321
Medical assistance unit:
Bureau of Health Insurance and Medical Assistance
Department of Health
Franklin Building
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809/774-4624
Virgina (region III):
Single State agency:
State Department of Health
109 Governor Street
Richmond, Virginia 23219
804/786-3561
Medical assistance unit:
Medical Assistance Program
State Department of Health
109 Governor Street
Richmond, Virginia 23219
804/786-7933
Washington (region X):
Single State agency:
Department of Social and Health Services
Mail Stop OB-44
Olympia, Washington 98504
206/753-3395
Medical assistance unit:
Office of Medical Assistance
Department of Social and Health Services
Mail Stop LK-11
Olympia, Washington 98504
206/753-5839
West Virginia (region III):
Single State agency:
West Virginia Department of Welfare
1900 Washington Street, East
Charleston, West Virginia 25305
304/348-2400
Medical assistance unit:
Division of Medical Care
Department of Welfare
1900 Washington Street, East
Charleston, West Virginia 25305
304/348-8990
Wisconsin (region V):
Single State agency:
Department of Health and Social Services
One West Wilson Street
Madison, Wisconsin 53702
608/266-3681
Medical assistance unit:
Bureau of Health Financing Control
Division of Health
Department of Health and Social Service
One West Wilson Street
Madison, Wisconsin 53702
608/266-2522
Wyoming (region VIII):
Single State agency:
Department of Health and Social Services
Hathaway Building
Cheyenne, Wyoming 82002
307/328-9657
Medical assistance unit:
Medical Assistance Services
Division of Health and Social Services
Department of Health and Social Services
State Office Building
Cheyenne, Wyoming 82002
307/777-9533

APPENDIX F. TITLE XX STATE AGENCY DIRECTORS

Region I

CONNECTICUT

Ronald Manning, Commissioner
Department of Human Resources
1179 Main Street
Hartford, Connecticut 06115
(203) 566-3318

MAINE

Michael R. Petit, Commissioner
State Department of Human Services
State House
Augusta, Maine 04333
(207) 289-2736

MASSACHUSETTS

Dr. Mary Jane England
Commissioner
Department of Social Services
150 Causeway Street
Boston, Massachusetts 02114
(617) 727-0594

NEW HAMPSHIRE

Mr. Edgar J. Helms, Jr
Commissioner
Department of Health and Welfare
Hazen Drive
Concord, New Hampshire 03301
FTS 8-842-3331

RHODE ISLAND

John J. Affleck, Director
State Department of Social and Rehabilitative Services
Aime J. Forand State Office Building
600 New London Avenue
Cranston, Rhode Island 02920
(401) 464-2121

VERMONT

Sister Elizabth Candon
Secretary
Agency of Human Services
State Office Building
79 River Street
Montpelier, Vermont 05602
(820) 244-5181

Region II

NEW JERSEY

Mrs. Ann Klein
Commissioner
Department of Human Services
Capital Place One
222 South Warren Street
Trenton, New Jersey 08625
(609) 292-3717

NEW YORK

Mrs. Barbara Blum
Commissioner
Department of Social Services
40 North Pearl Street
Albany, New York 12243
(518) 474-9475

PUERTO RICO

Dr. Jenaro Collazo-Collazo
Secretary
Department of Social Services
P.O. Box 11697
Santurce, Puerto Rico 00908
(809) 723-9834

VIRGIN ISLANDS

Mrs. Gwendolyn C. Blake
Commissioner
Department of Social Welfare
P.O. Box 539, Charlotte Amalie
St. Thomas, Virgin Islands 00801
(809) 774-0930

Region III

DELAWARE

Patricia C. Schramm
Department of Health and Social Services
Delaware State Hospital
Business Administration and General Services
New Castle, Delaware 19720
(302) 421-6705

DISTRICT OF COLUMBIA

James A. Buford, Director
Department of Human Services
Presidential Building—Room 407
415 12th Street, N.W.
Washington, D.C. 20004

MARYLAND

Mr. Kalman Hettleman, Secretary
Department of Human Resources
1100 N. Eutaw Street
Baltimore, Maryland 21202
(301) 383-5525
8-932-383-5528 (FTS)

PENNSYLVANIA

Ms. Helen B. O'Bannon, Secretary
Pennsylvania Department of Public Welfare
Health and Welfare Building
Harrisburg, Pennsylvania 17120
(717) 787-2600
8-637-2600 (FTS)

VIRGINIA

Mr. William L. Lukhard, Commissioner
Department of Welfare
8007 Discovery Drive
Richmond, Virginia 23288
8-804-770-2291 (FTS)

Mr. William T. Coppage, Director
Virginia Commission for Visually Handicapped
3003 Parkwood Avenue
Richmond, Virginia 23221
8-804-770-2181 (FTS)

WEST VIRGINIA

Mr. Leon H. Ginsberg, Ph.D.
Commissioner
State Department of Welfare
Building B—Room 617
1900 Washington Street, East
Charleston, West Virginia 25305
(304) 348-2400
8-885-2500 (FTS)

Region IV

ALABAMA

Gary Cooper, Commissioner
State Department of Pensions and Security
64 North Union Street
Montgomery, Alabama 36130
(205) 832-6095

FLORIDA

David Pingree, Secretary
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
(904) 488-7721

GEORGIA

Dr. Douglas Skelton, Commissioner
Department of Human Resources
State Office Building
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334
(404) 656-5680

KENTUCKY

Mr. Joe Edwards, Commissioner
Mr. Grady Stumbo, Secretary
Department of Human Resources
275 East Main Street
Frankfort, Kentucky 40601
(502) 564-7130
FTS 8-351-7130

MISSISSIPPI

Jack Byars, Commissioner
State Department of Public Welfare
P.O. Box 4321 Fondren Station
Jackson, Mississippi 39216
(601) 956-8713

NORTH CAROLINA

Dr. Sarah Morrow, Secretary
Department of Human Resources
325 N. Salisbury Street
Raleigh, North Carolina 27611
(919) 829-4534

SOUTH CAROLINA

Virgil L. Conrad, Commissioner
Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
(803) 758-3244

TENNESSEE

Sammie Lynn Puett, Commissioner
State Department of Human Services
111 Seventh Avenue, North
Nashville, Tennessee 37230
(615) 741-3243
FTS 8-853-3243

Region V

ILLINOIS

Mr. Jeffrey C. Miller, Acting Director
Illinois Department of Public Aid
316 South Second Street, 3rd Floor
Springfield, Illinois 62762
(217) 782-6716
FTS 8-956-6716

INDIANA

Ms. Judith G. Palmer, Chairman
Interdepartmental Board for the Coordination of Human Services Programs
210 State House
Indianapolis, Indiana 46204
(317) 633-5288
FTS 8-336-5288

MICHIGAN

Dr. John T. Dempsey, Director
Michigan Department of Social Services
300 South Capitol Avenue
Lansing, Michigan 48926
(517) 373-2000
FTS 8-253-2000

MINNESOTA

Mr. Arthur Noot, Commissioner
Minnesota Department of Public Welfare
Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155
(612) 296-2701
FTS 8-776-2701

OHIO

Mr. Kenneth B. Creasy, Director
Ohio Department of Public Welfare
State Office Tower, 32nd Floor
30 East Broad Street
Columbus, Ohio 43215
(614) 466-6282
FTS 8-942-6282

WISCONSIN

Mr. Donald Percy, Secretary
Wisconsin Department of Health and Social Services
1 West Wilson Street
Madison, Wisconsin 53702
(608) 266-3681
FTS 8-366-3681

Region VI

ARKANSAS

Ms. Gail Huecker, Director
Arkansas Department of Human Services
1428 Donaghey Building
Little Rock, Arkansas 72201
(501) 371-1157
118-9-371-1001
110-569-371-1157

LOUISIANA

George Fischer, Secretary
Department of Health and Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
FTS 8-689-5797

NEW MEXICO

Lawrence B. Ingram, Secretary
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
FTS 8-476-5151

OKLAHOMA

L. E. Rader, Director
Department of Institutions
Social and Rehabilitative Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
(405) 521-3076

TEXAS

Jerome D. Chapman, Commissioner
Texas Department of Human Resources
John H. Reagan Building
Austin, Texas 78701
(512) 475-5777
110-53-9-475-5777

Region VII

IOWA

Mrs. Barbara Jackson
Chief, Division of Social Services
Hoover State Office Building
East 14th and Walnut
Des Moines, Iowa 50319
(515) 281-5452
FTS 8-281-5452

KANSAS

Mr. Lauren Harrod
Chief, Social Services
Kansas Department of Social and Rehabilitation Services
State Office Building
Topeka, Kansas 66612
FTS 8-757-3271

MISSOURI

Mr. Richard L. Matt
Title XX Administrator
Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, Missouri 65102
(314) 751-4815

NEBRASKA

Mr. Edward Schulenburg
Chief, Division of Social Services
State Department of Public Welfare
301 Centennial Mall, South
Lincoln, Nebraska 68509
FTS 8-541-3121

Region VIII

COLORADO

Reuben Valdez, Executive Director
State Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
(303) 839-3515

MONTANA

Keith L. Colbo, Director
Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59601
(406) 449-5622
FTS 8-587-5622

NORTH DAKOTA

Thor Tangedahl, Executive Director
Social Service Board of North Dakota
State Capitol
Bismarck, North Dakota 58505
(701) 224-2310
FTS 8-783-4011

SOUTH DAKOTA

James Ellenbecker, Secretary
Department of Social Services
Kneip Building
Pierre, South Dakota 57501
(605) 773-3165
FTS 8-782-7000

UTAH

Dr. Anthony W. Mitchell, Executive Director
Department of Social Services
150 West North Temple
Salt Lake City, Utah 84103
(801) 533-5331
FTS 8-588-5500

WYOMING

W. Don Nelson, Director
Department of Health and Social Services
Hathaway Building
Cheyenne, Wyoming 82002
(777) 728-9657
FTS 8-328-9657

Region IX

ARIZONA

Mr. Bill Jamieson, Jr., Director
Department of Economic Security (DES)
1717 West Jefferson
P.O. Box 6123
Phoenix, Arizona 85005
(602) 255-5678
FTS 8-765-5678

CALIFORNIA

Marion J. Woods, Director
Department of Social Services
744 P Street
Sacramento, California 95814
(916) 445-2077
FTS 8-445-2077

HAWAII

Mr. Andrew I. T. Chang, Director
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
Office Location: 1390 Miller Street
(808) 548-6260

NEVADA

Dr. Ralph DiSibio
Department of Human Resources
505 East King Street
Carson City, Nevada 89701
882-4730 (Dial thru FTS Reno
Operator 8-470-5911)

GUAM

Dr. Franklin Cruz, Director
Department of Public Housing and Social Services
P.O. Box 2816
Agana, Guam 96910
(617) 734-9901

Region X

ALASKA

Dr. Helen D. Beirne, Commissioner
Department of Health and Social Services
Pouch H 01
Juneau, Alaska 99811
(Operator Places Call)
FTS 8-465-5440

IDAHO

Milton G. Klein, Director
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
FTS 8-554-2336

OREGON

Leo T. Hegstrom, Director
Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
FTS 8-530-3034

WASHINGTON

Gerald J. Thompson, Secretary
Department of Social and Health Services
MS OB 44
Olympia, Washington 98504
FTS 8-434-3395

APPENDIX G. VA INSTALLATIONS—WHERE TO GO FOR HELP

"VA—May I Help You?"

For information or assistance in applying for veterans' benefits, write, call, or visit a Veterans Benefits Counselor at your nearest VA regional office or VA office listed on the following pages, or a local veterans service organization representative. Application for medical benefits may be made at a VA medical center (see H—Hospital Care below) or any VA station with medical facilities.

All 50 States have toll-free telephones services to VA regional offices. The telephone numbers listed after each regional office are the toll-free benefits information numbers to that office for the areas shown. Local telephone numbers are also listed for VA hospitals and clinics.

Please note: Telephone numbers are subject to change. If you are unable to reach VA at the number listed for your area or if you are unsure which number to call, consult the white pages of your local telephone directory under U.S. Government, Veterans Administration, for the benefits information number. The directory assistance operator can also assist you.

GI life insurance is administered at the VA Center in St. Paul or Philadelphia. For any information concerning a policy, write directly to the VA Center administering it. Give the insured's policy number, if known. The insured's full name, date of birth, and service number should be given if the policy number is not known.

VA Installations—Where To Go for Help

VA installations are listed below by State. Information on VA benefits may be obtained from the following installations: Regional Offices (RO); other offices (O); Centers (C) (Regional Offices and Insurance); and United States Veterans Assistance Centers (USVAC) listed immediately following the State listing. Abbreviations of other installations are as follows: H—Hospital Care; D—Domiciliary Care; NHC—Nursing Home Care; OC—Outpatient Clinic (independent); OCH—Outpatient Clinic (physically separated from hospital); OCS—Outpatient Clinic Substation.

ALABAMA

Birmingham (H) 35233
700 S. 19th St.
(205) 933-8101

Mobile (OCS) 36617
2451 Fillingim St.
(205) 690-2875

Montgomery (H) 36109
215 Perry Hill Rd.
(205) 272-4670

Montgomery (RO) 36104
474 S. Court St.
If you reside in the local telephone area of:
Birmingham — 322-2492
Huntsville — 539-7742
Mobile — 432-8645
Montgomery — 262-7781
All other areas in Alabama
(800) 392-8054

Tuscaloosa (H&NHC) 35401
Loop Rd.
(205) 553-3760

Tuskegee (H&NHC) 36083
(205) 727-0550

ALASKA

Anchorage (RO) 99501
Old Federal Building and Post Office
605 West 4th Ave.
If you live in the local telephone area of:
Anchorage 271-4053
All other Alaska communities ask operator for Zenith 2500

Juneau (OC) 99802
Federal Bldg., U.S. Post Office and Courthouse
709 W. 9th St.
(907) 586-7466

ARIZONA

Phoenix (H) 85012
7th St. & Indian School Rd.
(602) 277-55[illegible]1

Phoenix (RO) 85012
3225 N. Central Ave.
If you live in the local telephone area of:
Phoenix — 263-5411
Tucson — 622-6424
All other Arizona areas
(800) 352-0451

Prescott (H&D) 86313
(602) 445-4860

Tucson (H&NHC) 85723
3601 S. 6th Ave.
(602) 792-1450

ARKANSAS

Fayetteville (H) 72701
1100 N. College Ave.
(501) 443-2301

Little Rock (RO) 72201
1200 W. 3rd St.
If you live in the local telephone area of:
Fort Smith — 785-2637
Little Rock — 378-5971
Pine Bluff — 536-8100
Texarkana — 774-2166
All other Arkansas areas
(800) 482-8990

Little Rock (H&NHC) 72206
300 E. Roosevelt Rd.
(501) 372-8361

CALIFORNIA

Compton (USVAC) 90221
1717 N. Long Beach Blvd.
Suite 108
(213) 537-3203

East Los Angeles (USVAC) 90063
East L.A. Service Center
915 N. Bonnie Beach Pl.
(213) 264-1068

Fresno (H) 93703
2615 E. Clinton Ave.
(209) 227-2941

Livermore (H) 94550
(415) 447-2560

Loma Linda (H) 92357
11201 Benton St.
(714) 824-0850

Long Beach (H&NHC) 90822
5901 E. 7th St.
(213) 498-1313

Los Angeles (RO) 90024
Federal Building
11000 Wilshire Blvd.
West Los Angeles

Counties of Inyo, Kern, Los Angeles, Orange, San Bernardino, San Luis Obispo, Santa Barbara and Ventura:

If you live in the local telephone area of:
Central LA — 879-1303
Inglewood — 645-5420
La Crescenta — 248-0450
Malibu — 451-0672

San Fernando — 997-6401
San Pedro — 833-5241
Sierra Madre — 355-3305
West Los Angeles — 479-4011
Whittier — 945-3841

Outside LA
Anaheim — 821-1020
Bakersfield — 834-3142
Huntington Beach — 848-1500
Ontario — 983-9784
Oxnard — 487-3977
San Bernardino — 884-4874
Santa Ana — 543-8403
Santa Barbara — 963-0643

All other areas of the above counties — (800) 352-6592

Counties of Alpine, Lassen, Modoc and Mono served by:
Reno, NV (RO) 89520
1201 Terminal Way

If you live in the above California counties —
(800) 648-5406

Los Angeles (H&D) 90073
Sawtelle & Wilshire Blvd.
(213) 478-3711

Los Angeles (OC) 90013
425 S. Hill St.
(213) 688-2000

Martinez (H) 94553
150 Muir Rd.
(415) 228-6800

Oakland (OCS) 94612
1515 Clay St.
(415) 273-7125

Palo Alto (H&NHC) 94304
3801 Miranda Ave.
(415) 493-5000

San Diego (RO) 92108
2022 Camino Del Rio North Counties of Imperial, Riverside, and San Diego:
If you live in the local telephone area of:
Riverside — 686-1132
San Diego — 297-8220
All other areas of the above counties (800) 532-3811

*San Diego (H&NHC) 92161
3350 LaJolla Village Dr.
(714) 453-7500

San Diego (OCH) 92108
Palomar Building
2022 Camino Del Rio North

San Francisco (RO) 94105
211 Main St.
If you live in the local telephone area of:
Fremont — 796-9212
Fresno — (800) 652-1296
Modesto — 521-9260
Monterey — 649-3550
Oakland — 893-0405
Palo Alto — 321-5615
Sacramento — 929-5863
San Francisco — 495-8900
San Jose — 998-7373
Santa Rosa — 544-3520
Stockton — 948-8860
Vallejo — 552-1556
All other areas of Northern California — (800) 652-1240

San Francisco (H) 94121
4150 Clement St.
(415) 221-4810

Sepulveda (H&NHC) 91343
16111 Plummer
(213) 894-8271

COLORADO

Denver (RO) 80225
Building 20
Denver Federal Center
If you live in the local telephone area of:
Colorado Springs — 475-9911
Denver — 233-6300
Pueblo — 545-1764
All other Colorado areas — (800) 332-6742

Denver (H) 80220
1055 Clermont St.
(303) 399-8020

Fort Lyon (H&NHC) 81038
(303) 456-1260

Grand Junction (H&NHC) 81501
2121 North Ave.
(303) 242-0731

CONNECTICUT

Hartford (RO) 06103
450 Main St.
If you live in the local telephone area of:
Bridgeport — 384-9861
Danbury — 743-2791
Hartford — 278-3230
New Haven — 562-2113/6127
New London — 447-0377
Norwalk — 853-8141
Stamford — 325-4039
Waterbury — 757-0347
All other Connecticut areas — (800) 842-4315/4317

Newington (H) 06111
555 Willard Ave.
(203) 666-6951

West Haven (H&NHC) 06516
W. Spring St.
(203) 933-2561

DELAWARE

Wilmington (RO) 19805
1601 Kirkwood Highway
If you live in the local telephone area of:
Wilmington — 998-0191
All other Delaware areas —
(800) 292-7855

Wilmington (H) 19805
1601 Kirkwood Highway
(302) 994-2511

DISTRICT OF COLUMBIA

Washington, D.C. (RO) 20421
941 N. Capitol St., N.E.
(202) 872-1151

Washington, D.C. (H) 20422
50 Irving St., N.W.
(202) 483-6666

FLORIDA

Bay Pines (H.D. NHC, & OCH) 33504
1000 Bay Pines Blvd., N.
(813) 391-9644

Gainesville (H) 32602
Archer Rd.
(904) 376-1611

Jacksonville (O) 32201
Post Office & Courthouse Bldg.
311 W. Monroe St.
(904) 356-1581

Jacksonville (OCS) 32206
1833 Boulevard
(904) 791-2751

Lake City (H&NHC) 32055
S. Marion St.
(904) 752-1400

Miami (H&NHC) 33125
1201 N.W. 16th St.
(305) 324-4455

Miami (O) 33130
Federal Building, Rm. 100
51 S.W. 1st Ave.
(305) 358-0669

Orlando (OCS) 32806
83 W. Columbia St.
(305) 425-7521

Riviera Beach (OPC) 33404
Exec. Plaza, 301 Broadway
(305) 845-2800

St. Petersburg (OCH) 33731
144 First Ave., S
(813) 893-3706

St. Petersburg (RO) 33731
144 1st Ave. S.
If you live in the local telephone area of:
Cocoa/Cocoa Beach — 783-8930
Daytona Beach — 255-8351
Ft. Lauderdale/Hollywood — 522-4725
Ft. Myers — 334-0900
Gainesville — 376-5266
Jacksonville — 356-1581
Lakeland/Winter Haven — 688-7499
Melbourne — 724-5600
Miami — 358-0669
Orlando — 425-2626
Pensacola — 434-3537
Sarasota — 366-2939
Tallahassee — 224-6872
Tampa — 229-0451
West Palm Beach — 833-5734
St. Petersburg — 898-2121
All other Florida areas —
(800) 282-8821

Tampa (H) 33612
13000 N. 30th St.
(813) 971-4500

GEORGIA

Atlanta (RO) 30308
730 Peachtree St., N.E.
If you live in the local telephone area of:
Albany — 439-2331
Atlanta — 881-1776
Augusta — 738-5403
Columbus — 324-6646
Macon — 745-6517
Savannah — 232-3365

All other Georgia areas —
(800) 282-0232

Augusta (H&NHC) 30904
(404) 733-4471

Decatur (H) 30033
1670 Clairmont Rd., N.E.
(404) 321-6111

Dublin (H. D. & NHC) 31021
(912) 272-1210

HAWAII

Honolulu (RO) 96813
PJKK Federal Bldg.

300 Ala Moana Blvd.
If you live in the local telephone area of:
Is. of Hawaii — Ask operator for Enterprise 5308
Is. of Kauai — Ask operator for Enterprise 5310
Is. of Maui/Lanai/Molokai — Ask operator Enterprise 5309
Is. of Oahu — 546-8962

Honolulu Clinic 96801
P.O. Box 3198
680 Ala Moana Blvd.
(808) 546-2176

IDAHO

Boise (RO) 83724
Federal Bldg. and U.S. Courthouse
550 W. Fort St.
If you live in the local telephone area of:
Boise — 384-1010
All other Idaho areas —
(800) 632-2003

Boise (H) 83702
5th and Fort St.
(208) 342-3681

ILLINOIS

Chicago (H) 60611
333 E. Huron St. (Lakeside)
(312) 943-6600

Chicago (H) 60680
(West Side)
820 S. Damen Ave.
(312) 666-6500

Chicago (RO) 60680
536 S. Clark St.
If you live in the local telephone area of:
Bloomington/Normal — 829-4374
Carbondale — 457-8161
Champaign-Urbana — 344-7505
Chicago — 663-5510
Decatur — 429-9445
E. St. Louis — 274-5444
Peoria — 674-0901
Rockford — 968-0538
Springfield — 789-1246
All other Illinois areas —
(800) 972-5327

Danville (H&NHC) 61832
(217) 442-8000

Hines (H) 60141
(312) 343-7200

Marion (H) 62959
(618) 997-5311

North Chicago (H&NHC) 60064
Downey
(312) 689-1900

INDIANA

Evansville (OCS) 47708
214 S.E. 6th St.
(812) 423-6871 Ext. 316

Fort Wayne (H&NHC) 46805
1600 Randalia Dr.
(219) 743-5431

Indianapolis (RO) 46204
575 N. Pennsylvania St.
If you live in the local telephone area of:
Anderson/Muncie — 289-9377
Evansville — 426-1403
Ft. Wayne — 422-9189
Gary/Hammond/E. Chicago — 886-9184
Indianapolis — 269-5566
Lafayette/W. Lafayette — 742-0084
South Bend — 232-3011
Terre Haute — 232-1030
All other Indiana areas — (800) 382-4540

Indianapolis (H&NHC) 46202
1481 W. 10th St.
(317) 635-7401

Marion (H&NHC) 46952
E. 38th St.
(317) 674-3321

IOWA

Des Moines (RO) 50309
210 Walnut St.
If you live in the local telephone area of:
Cedar Rapids — 366-7681
Davenport/Rock Is./Moline, IL — 326-4051
Des Moines — 280-7220
Sioux City — 252-3291
Waterloo — 235-6721
All other Iowa areas —
(800) 362-2222

Des Moines (H) 50310
30th & Euclid Ave.
(515) 255-2173

Iowa City (H) 52240
(319) 338-0581

Knoxville (H&NHC) 50138
1515 W. Pleasant St.
(515) 842-3101

KANSAS

Leavenworth (H, D. & NHC) 66048
4201 S. 4th St., Trafficway
(913) 682-2000

Topeka (H&NHC) 66622
2200 Gage Blvd.
(913) 272-3111

Wichita (RO) 67211
Blvd. Office Park
901 George Washington Blvd.
If you live in the local telephone area of:
Kansas City — 432-1650
Topeka — 357-5301
Wichita — 264-9123
All other Kansas areas —
(800) 362-2444

Wichita (H) 67218
5500 E. Kellogg
(316) 685-2221

KENTUCKY

Lexington (H&NHC) 40507
(606) 233-4511

Louisville (RO) 40202
600 Federal Place
If you live in the local telephone area of:
Lexington — 253-0566
Louisville — 584-2231
All other areas —
(800) 292-4562

Louisville (H) 40202
800 Zorn Ave.
(502) 895-3401

LOUISIANA

Alexandria (H&NHC) 71301
(318) 442-0251

New Orleans (RO) 70113
701 Loyola Ave.
If you live in the local telephone area of:
Baton Rouge — 343-5539
New Orleans — 561-0121
Shreveport — 424-8442
All other Louisiana areas —
(800) 462-9510

New Orleans (H) 70146
1601 Perdido St.
(504) 568-0811

Shreveport (H&O) 71130
510 E. Stoner Ave.
(318) 424-8442 (Office)
(318) 221-8411 (Hospital)

MAINE

Portland (O) 04111
One Maine Savings Plaza
Congress St.
(207) 775-6391

Togus (RO) 04330
If you live in the local telephone area of:
Portland — 775-6391
All other Maine areas —
(800) 452-1935

Togus (H&NHC) 04330
(207) 623-8411

MARYLAND

Counties of Montgomery and Prince Georges:
Washington, DC (RO) 20421
941 N. Capitol St., N.E.
If you live in the above Maryland counties —
872-1151

All other Maryland counties:
Baltimore (RO) 21201
31 Hopkins Plaza
Federal Building
If you live in the local telephone area of:
Baltimore — 685-5454
All other Maryland areas:
(800) 492-9503

Baltimore (OCH) 21201
31 Hopkins Plaza
Federal Building
(301) 962-4610

Baltimore (H) 21218
3900 Loch Raven Blvd.
(301) 467-9932

Fort Howard (H&NHC) 21052
(301) 477-1800

Perry Point (H&NHC) 21902
(301) 962-4725

MASSACHUSETTS

Bedford (H&NHC) 01730
200 Spring Rd.
(617) 275-7500

Boston (H) 02130
150 S. Huntington Ave.
(617) 232-9500

Towns of Fall River and New Bedford and counties of Barnstable, Dukes, Nantucket, part of Plymouth, and Bristol are served by
Providence, R.I. (RO) 02903
321 S. Main St.
If you live in the local telephone area of:
Fall River — 676-3898
New Bedford — 999-1321
All other areas of Dukes, Nantucket, Barnstable, and parts of Plymouth, and Bristol counties —
(800) 556-3893

Remaining Massachusetts counties served by:

Boston (RO) 02203
John Fitzgerald Kennedy Federal Bldg.
Government Center

If you live in the local telephone area of:
Boston — 227-4600
Brockton — 588-0764
Fitchburg/Leominster — 342-8927
Lawrence — 687-3332
Lowell — 455-5463
Springfield — 785-5343
Worchester — 791-3595

All other Massachusetts areas — (800) 392-6015

Boston (OC) 02108
17 Court St.
(617) 223-2021

Brockton (H&NHC) 02401
945 Belmont St.
(617) 583-4500

Lowell (OCS) 01852
Old Post Office Bldg.
50 Kearney Square
(617) 453-1746

New Bedford (OCS) 02740
53 N. Sixth St.
(617) 997-8721

Northampton (H&NHC) 01060
N. Main St.
(413) 584-4040

Springfield (O) 01103
1200 Main St.
(413) 785-5343

Springfield (OCS) 01103
101 State St.
(413) 781-2420

West Roxbury (H) 02132
1400 VFW Parkway
(617) 323-7700

Worchester (OCS) 01601
595 Main St.
(617) 791-2251

MICHIGAN

Allen Park (H&NHC) 48101
Southfield & Outer Drive
(313) 562-6000

Ann Arbor (H) 48105
2215 Fuller Rd.
(313) 769-7100.

Battle Creek (H&NHC) 49016
(616) 965-3281

Detroit (RO) 48226
Patrick V. McNamara Federal Bldg.
477 Michigan Ave.
If you live in the local telephone area of:
Ann Arbor — 662-2506
Battle Creek — 962-7568
Bay City — 894-4556
Detroit — 964-5110
Flint — 234-8646
Grand Rapids — 456-8511
Jackson — 787-7030
Kalamazoo — 344-0156
Lansing/E. Lansing — 484-7713
Muskegon — 726-4895
Saginaw — 754-7475
All other Michigan areas —
(800) 482-0740

Grand Rapids (OCS) 49503
260 Jefferson St., S.E.
(616) 459-2200

Iron Mountain (H&NHC) 49801
(906) 774-3300

Saginaw (H) 48602
1500 Weiss St.
(517) 793-2340

MINNESOTA

Minneapolis (H) 55417
54th St. & 48th Ave. South
(612) 725-6767

St. Cloud (H&NHC) 56301
(612) 252-1670

St. Paul (C) 55111
Federal Bldg. Fort Snelling
If you live in the local telephone area of:
Duluth — 722-4467
Minneapolis — 726-1454
Rochester — 288-5888
St. Cloud — 253-9300
St. Paul — 726-1454
All other Minnesota areas — (800) 692-2121

St. Paul (OCH) 55111
Fort Snelling
(612) 725-6767

MISSISSIPPI

Biloxi (H,D&NHC) 39531
(601) 388-5541
Jackson (H&NHC) 39216
1500 E. Woodrow Wilson Ave.
(601) 362-4471

Jackson (RO) 39201
100 W. Capitol St.
If you live in the local telephone area of:
Biloxi/Gulfport — 432-5996
Jackson — 969-4873

Meridian — 693-6166
All other Mississippi areas —
(800) 682-5270

MISSOURI

Columbia (H&NHC) 65201
800 Stadium Road
(314) 443-2511

Kansas City (H) 64128
4801 Linwood Blvd.
(816) 861-4700

Kansas City (O) 64106 Federal Office Bldg.
601 E. 12th St.
(816) 861-3761

Poplar Bluff (H&NHC) 63901
(314) 686-4451

St. Louis (RO) 63103
Federal Bldg.
1520 Market St.
If you live in the local telephone area of:
Columbia — 449-1276
Kansas City — 861-3761
St. Joseph — 364-1171
St. Louis — 342-1171
Springfield — 883-7470
All other Missouri areas —
(800) 392-3761

St. Louis (H&NHC) 63125
915 N. Grand Blvd.
(314) 652-4100

MONTANA

Fort Harrison (RO) 59636
If you live in the local telephone area of:
Fort Harrison/Helena — 442-6410
Great Falls — 761-3215
All other Montana areas — (800) 332-6125

Fort Harrison (H) 59636
(406) 442-6410

Miles City (H&NHC) 59301
210 S. Winchester
(406) 232-3060

NEBRASKA

Grand Island (H&NHC) 68801
2201 N. Broadway
(308) 382-3660

Lincoln (RO) 68508
Federal Bldg.
100 Centennial Mall North
If you live in the local telephone area of:
Lincoln — 471-5001
Omaha/Council Bluff — 221-3291
All other Nebraska areas —
(800) 742-7554

Lincoln (H) 68510
600 S. 70th St.
(402) 867-6011

Omaha (H) 68105
4101 Woolworth Ave.
(402) 346-8800

NEVADA

Henderson (CS) 89015
102 Lake Mead Dr.
(702) 564-2420

Reno (H&NHC) 89520
1000 Locust St.
(702) 329-1051

Reno (RO) 89250
1201 Terminal Way
If you live in the local telephone area of:
Las Vegas — 386-2921
Reno — 329-9244
All other Nevada areas —
(800) 992-5740

NEW HAMPSHIRE

Manchester (RO) 03103
Norris Cotton Federal Bldg.
275 Chestnut St.
If you live in the local telephone area of:
Manchester 666-7785
All other New Hampshire areas (800) 562-5260

Manchester (H&NHC) 03104
718 Smyth Rd.
(603) 624-4366

NEW JERSEY

East Orange (H&NHC) 07019
Tremont Ave. & S. Center
(201) 676-1000

Lyons (H&NHC) 07939
(201) 647-0180

Newark (RO) 07102
20 Washington Place
If you live in the local telephone area of:
Atlantic City — 348-8550
Camden — 541-8650
Clifton/Paterson/Passaic — 472-9632
Long Branch/Asbury Park — 870-2550
New Brunswick/Sayreville — 828-5600
Newark — 645-2150
Perth Amboy — 442-5300
Trenton — 989-8116
All other New Jersey areas — (800) 242-5867

Newark (OCH) 07102
20 Washington Place
(201) 645-3491

NEW MEXICO

Albuquerque (RO) 87102
Dennis Chavez Federal Bldg.
U.S. Courthouse
500 Gold Ave., S.W.
If you live in the local telephone area of:
Albuquerque — 766-3361
All other New Mexico areas — (800) 432-6853

Albuquerque (H&NHC) 87108
2100 Ridgecrest Dr., S.E.
(505) 265-1711

NEW YORK

Albany (H&NHC) 12208
113 Holland Ave.
(518) 462-3311

Albany (O) 12207
Leo W. O'Brien Federal Bldg.
Clinton Ave. & N. Pearl St.
(800) 442-5882

Batavia (H) 14020
Redfield Pkwy.
(716) 343-7500
Bath (H.D&NHC) 14810
(607) 776-2111

Bronx (H) 10468
130 W. Kingsbridge Rd.
(212) 584-9000

Brooklyn (H&NHC) 11209
800 Poly Place
(212) 836-6600

Brooklyn (OC) 11205
35 Ryerson St.
(212) 330-7850

Buffalo (RO) 14202
Federal Bldg.
111 W. Huron St.
If you live in the local telephone area of:
Binghampton — 772-0856
Buffalo — 846-5191
Rochester — 232-5290
Syracuse — 476-5544
Utica — 735-6431
All other areas of Western New York State — (800) 462-1130

Buffalo (H&NHC) 14215
3495 Bailey Ave.
(716) 834-9200

Canandaigua (H&NHC) 14424
Ft. Hill Ave.
(716) 394-2000

Castle Point (H&NHC) 12511
(914) 831-2000

Montrose (H&NHC) 10548
(914) 737-4400

New York City (H) 10010
1st Ave. at E. 24th St.
(212) 686-7500

New York City (RO) 10001
252 Seventh Ave. at 24th St.
Counties of Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester:
If you live in the local telephone area of:
Hempstead — 483-6188
New York — 620-6901
Poughkeepsie — 452-5330
Scarsdale — 723-7476
All other areas in the above counties — (800) 442-5882

New York City (OCH) 10001
252 7th Ave. at 24th St.
(212) 620-6776

New York City (Prosthetic Center) 10001
252 7th Ave.
(212) 620-6636

Northport (H) 11768
Long Island — Middleville Rd.
(516) 261-4400

Rochester (O&OCS) 14614
Federal Office Bldg. and Courthouse
100 State St.
(716) 232-5290 (O)
(716) 263-5734 (OCS)

Syracuse (O) 13202
U.S. Courthouse and Federal Building
100 S. Clinton St.
(315) 476-5544

Syracuse (Mental Hygiene Clinic) 13202
Gateway Bldg.
803 S. Salina St.
(315) 473-2619

Syracuse (H&NHC) 13210
Irving Ave. & University Pl.
(315) 476-7461

NORTH CAROLINA

Asheville (H&NHC) 28805
(704) 298-7911

Durham (H) 27705
508 Fulton St.
(919) 286-0411

Fayetteville (H&NHC) 28301
2300 Ramsey St.
(919) 488-2120

Salisbury (H&NHC) 28144
1601 Brenner Ave.
(704) 636-2351

Winston-Salem (OCH) 27102
Federal Bldg.
251 N. Main St.
(919) 761-3562

Winston-Salem (RO) 27102
Federal Bldg.
251 N. Main St.
If you live in the local telephone area of:
Asheville — 253-6861
Charlotte — 375-9351
Durham — 683-1367
Fayetteville — 323-1242
Greensboro — 274-1994
High Point — 887-1202
Raleigh — 821-1166
Winston-Salem — 748-1800
All other North Carolina areas — (800) 642-0841

NORTH DAKOTA

Fargo (RO) 58102
21st Ave. & Elm St.
If you live in the local telephone area of:
Fargo — 293-3656
All other North Dakota areas — (800) 342-4790

Fargo (H&NHC) 58102
2101 Elm St.
(701) 232-3241

OHIO

Brecksville (H&NHC) 44141
10000 Brecksville Rd.
(216) 526-3030

Chillicothe (H&NHC) 45601
(614) 773-1141

Cincinnati (H&NHC) 45220
3200 Vine St.
(513) 861-3100

Cincinnati (O) 45202
Rm. 1024, Federal Off. Bldg.
550 Main St.
(513) 579-0505

Cleveland (H) 44106
10701 E. Boulevard
(216) 791-3800

Cleveland (RO) 44199
Anthony J. Celebrezze Federal Bldg.
1240 E. 9th St.
If you live in the local telephone area of:
Akron — 535-3327
Canton — 453-8113
Cincinnati — 579-0505
Cleveland — 621-5050.
Columbus — 224-8872
Dayton — 223-1394
Springfield — 322-4907
Toledo — 241-6223
Warren — 399-8985
Youngstown — 744-4383
All other Ohio areas —
(800) 362-9024

Columbus (O) 43215
Rm. 309 Fed. Bldg.
200 N. High St.
(614) 224-8872

Columbus (OC) 43210
456 Clinic Drive
(614) 469-7365

Dayton (H.D&NHC) 45428
4100 W. 3rd St.
(513) 268-6511

OKLAHOMA

Muskogee (H) 74401
Memorial Station
Honor Heights Dr.
(918) 683-3261

Muskogee (RO) 74401
Federal Bldg.
125 S. Main St.
If you live in the local telephone area of:
Lawton — 357-2400
Muskogee — 687-2500
Oklahoma City — 235-2641
Stillwater — 377-1770
Tulsa — 583-5891
All other Oklahoma areas — (800) 482-2800

Oklahoma City (O) 73102
200 N.W. 4th St.
(405) 235-2641

Oklahoma City (H) 73104
921 N.E. 13th St.
(405) 272-9876

OREGON

Portland (H) 97207
3710 SW. U.S. Veterans Rd.
(503) 222-9221

Portland (RO) 97204
Federal Bldg.
1220 SW. 3rd Avenue
If you live in the local telephone area of:
Eugene/Springfield — 342-8274
Portland — 221-2431

Salem — 581-9343
All other Oregon areas — (800) 452-7276

Portland (OCH) 97204
426 S.W. Stark St.
(503) 221-2575
Roseburg (H&NHC) 97470
(503) 672-4411

White City (D) 97501
(503) 826-2111

PENNSYLVANIA

Altoona (H&NHC) 16603
Pleasant Valley Blvd.
(814) 943-8164

Butler (H&NHC) 16001
(412) 287-4781

Coatesville (H&NHC) 19320
Black Horse Rd.
(215) 384-7711

Erie (H&NHC) 16501
135 E. 38th St. Blvd.
(814) 868-8661

Harrisburg (OCS) 17108
Federal Bldg.
228 Walnut St.
(717) 782-4590

Lebanon (H&NHC) 17042
(717)272-6621

Philadelphia (H) 19104
University & Woodland Aves.
(215) 382-2201

Philadelphia (OCH) 19102
1421 Cherry St.
(215) 597-3311
Ask for OCH

Philadelphia (C) 19101
P.O. Box 8079
5000 Wissahickon Ave.

Counties of Adams, Berks, Bradford, Bucks, Cameron, Carbon, Centre, Chester, Clinton, Columbia, Cumberland, Dauphin, Delaware, Franklin, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York:
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Allentown/Bethlehem/Easton — 821-6823
Harrisburg — 232-6677
Lancaster — 394-0596
Philadelphia — 438-5225
Reading — 376-6548
Scranton — 961-3883
Wilkes-Barre — 824-4636
Williamsport — 322-4649
York — 845-6686
All other areas in the above counties — (800) 822-3920

Pittsburgh (RO) 15222
1000 Liberty Ave.
If you live in the local telephone area of:
Altoona — 944-7101
Johnstown — 535-8625
Pittsburgh — 281-4233
All other areas in Western Pennsylvania — (800) 242-0233

Pittsburgh (OCH) 15222
1000 Liberty Ave.
(412) 644-6750

Pittsburgh (H&NHC) 15240
University Drive C.
(412) 683-3000

Pittsburgh (H) 15206
Highland Drive
(412) 363-4900

Wilkes-Barre (O) 18701
19-27 N. Main St.
(717) 824-4636

Wilkes-Barre (H) 18711
1111 E. End Blvd.
(717) 824-3521

PHILIPPINES

Manila (RO) 96528
1131 Roxas Bldv. (Manila)
APO San Francisco (Air Mail)

PUERTO RICO

Mayaguez (OCS) 00708
Road Number 2
(809) 833-4600
Ask for Ext. 204

Ponce (OCS) 00731
Calle Isabel No. 60
(809) 843-5151

San Juan (H) 00921
Barrio Monacillos
Rio Piedras GPO Box 4867
(809) 843-5151

San Juan (RO) 00918
U.S. Courthouse & Fed. Bldg.
Carlos E. Chardon St.
Hato Rey
(809) 753-4141

RHODE ISLAND

Providence (RO) 02903
321 S. Main St.
If you live in the local telephone area of:
Providence — 528-4431
All other Rhode Island areas — Ask operator for Enterprise 5050

Providence (H) 02908
Davis Park
(401) 521-1700

SOUTH CAROLINA

Charleston (H) 29403
109 Bee St.
(803) 577-5011

Columbia (RO) 29201
1801 Assembly St.
If you live in the local telephone area of:
Charleston — 723-5581
Columbia — 765-5861
Greenville — 232-2457
All other South Carolina areas — (800) 922-1000

Columbia (H&NHC) 29201
Garners Ferry Rd.
(803) 776-4000

Greenville (OCS) 29607
Piedmont East Bldg.
37 Villa Road
(803) 232-7303

SOUTH DAKOTA

Fort Meade (H) 57741
(605) 347-2511

Hot Springs (H&D) 57747
(605) 745-4101

Sioux Falls (H&NHC) 57101
2501 W. 22nd St.
(605) 336-3230

Sioux Falls (RO) 57101
Courthouse Plaza Bldg.
300 North Dakota Ave.
If you live in the local telephone area of:
Sioux Falls — 336-3496
All other South Dakota areas
— (800) 952-3550

TENNESSEE

Chattanooga (OCS) 37411
Bldg. 6300 East Gate Center
(615) 266-3151

Knoxville (OCS) 37919
9047 Executive Park Dr.
Suite 100
(615) 637-9300

Memphis (H) 38104
1030 Jefferson Ave.
(901) 523-8990

Mountain Home (H.D&NHC) 37684
Johnson City
(615) 928-0281

Murfreesboro (H&NHC) 37130
(615) 893-1360

Nashville (RO) 37203
110 9th Ave., S.
If you live in the local telephone area of:
Chattanooga — 267-6587
Knoxville — 546-5700
Memphis — 527-4583
Nashville — 254-5411
All other Tennessee areas — (800) 342-8330

Nashville (H) 37203
1310 24th Ave. S.
(615) 327-4751

TEXAS

Amarillo (H) 79106
6010 Amarillo Blvd. W.
(806) 355-9703

Beaumont (OCS) 77701
3385 Fannin St.
(713) 838-0271

Big Spring (H&NHC) 79720
2400 S. Gregg St.
(915) 263-7361

Bonham (H.D&NHC) 75418
Ninth & Lipscomb
(214) 583-2111

Corpus Christi (OCS) 78404
1502 S. Brownlee Blvd.
(512) 888-3251

Dallas (O) 75202
U.S. Courthouse and Fed. Office Bldg.
1100 Commerce St.
(214) 824-5440

Dallas (H) 75216
4500 S. Lancaster Rd.
(214) 376-5451

El Paso (OC) 79925
5919 Brook Hollow Dr.
(915) 543-7890

Houston (RO) 77054
2515 Murworth Dr.

Counties of Angelina, Aransas, Atascosa, Austin, Bandera, Bee, Bexar, Blanco, Brazoria, Brewster, Brooks, Caldwell, Calhoun, Cameron, Chambers, Colorado, Comal, Crockett, DeWitt, Dimmitt, Duval, Edwards, Fort Bend, Frio, Galveston, Gillispie, Goliad, Gonzales, Grimes, Guadalupe, Hardin, Harris, Hays, Hidalgo, Houston, Jackson, Jasper, Jefferson, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kerr, Kimble, Kinney, Kleberg, LaSalle, Lavaca, Liberty, Live Oak, McCulloch, McMullen, Mason, Matagorda, Maverick, Medina, Menard, Montgomery, Nacogdoches, Newton, Nueces, Orange, Pecos, Polk, Real, Refugio, Sabine, San Augustine, San Jacinto, San Patricio, Schleicher, Shelby, Starr, Sutton, Terrell, Trinity, Tyler, Uvalde, Val Verde, Victoria, Walker, Waller, Washington, Webb, Wharton, Willacy, Wilson, Zapata, Zavala:
If you live in the local telephone area of:
Beaumont — 838-6222
Corpus Christi — 884-1994
Edinburg/McAllen/Pharr — 383-8168
Houston — 664-4664
San Antonio — 226-7661
Texas City/Galveston — 948-3011
All other areas in the above counties — (800) 392-2200

Houston (H&NHC) 77211
2002 Holcombe Blvd.
(713) 747-3000

Kerrville (H&NHC) 78028
(512) 896-2020

Lubbock (O&OC) 79401
Federal Building
1205 Texas Ave.
(806) 762-7415 (OC)
(806) 747-5256 (O)

Marlin (H) 76661
1016 Ward St.
(817) 883-3511

McAllen (OCS) 78501
1220 Jackson Ave.
(512) 682-4581

San Antonio (H) 78284
7400 Merton Minter Blvd.
(512) 696-9660

San Antonio (O) 78285
307 Dwyer Ave.
(512) 226-7661

San Antonio (OC) 78285
307 Dwyer Ave.
(512) 225-5511

Temple (H&D) 76501
1901 S. First
(817) 778-4811

Waco (RO) 76710
1400 N. Valley Mills Dr.
If you live in the local telephone area of:
Abilene — 673-5286
Amarillo — 376-7202
Austin — 477-5831
Dallas — 824-5440
El Paso — 545-2500
Ft. Worth — 336-1641
Killeen — 699-2351
Lubbock — 747-5256
Midland/Odessa/Terminal — 563-0324
Waco — 772-3060
Wichita Falls — 723-7103
All other areas in Texas — (800) 792-3271

Waco (H&NHC) 76703
Memorial Drive
(817) 752-6581

Waco (OCH) 76710
1400 N. Valley Mills Dr.
(817) 756-6511

UTAH

Salt Lake City (RO) 84138
Federal Bldg.
125 S. State St.
If you live in the local telephone area of:
Ogden — 399-4433
Provo/Orem — 375-2902
Salt Lake City — 524-5960
All other Utah areas — (800) 662-9163

Salt Lake City (H&NHC) 84148
500 Foothill Drive
(801) 582-1565

VERMONT

White River Junction (RO) 05001
If you live in the local telephone area of:
White River Junction — 295-9363
All other Vermont areas — (800) 622-4134

White River Junction (H&NHC) 05001
(802) 295-9363

VIRGINIA

Hampton (H,D&NHC) 23667
(804) 723-6501

Richmond (H) 23249
1201 Broad Rock Rd.
(804) 231-9011

Northern Virginia
Counties of Arlington and Fairfax and the cities of Alexandria, Fairfax, and Falls Church:

Washington, D.C. (RO) 20421
941 N. Capitol St., N.E.
If you live in the above Virginia counties or cities — 872-1151

Roanoke (RO) 24011
210 Franklin Rd., SW.
If you live in the local telephone area of:
Hampton — 722-7477
Norfolk — 627-0441/0442
Richmond — 648-1621/1622
Roanoke — 982-6440
All other Virginia areas — (800) 542-5826

Salem (H&NHC) 24153
(703) 982-2463

WASHINGTON

Seattle (RO) 98174
Federal Bldg.
915 2nd Ave.
If you live in the local telephone area of:
Everett — 259-9232
Seattle — 624-7200
Spokane — 747-3041
Tacoma — 383-3851
Yakima — 248-7970
All other Washington areas — (800) 552-7480

Seattle (H) 98108
4435 Beacon Ave., S.
(206) 762-1010

Seattle (OCH) 98104
Smith Tower, 2nd & Yesler
(206) 442-5030

Spokane (H) 99208
N. 4815 Assembly St.
(509) 328-4521

Tacoma (H&NHC) 98493
American Lake
(206) 588-2185

Vancouver (H) 98661
(206) 696-4061

Walla Walla (H) 99362
77 Wainwright Dr.
(509) 525-5200

WEST VIRGINIA

Beckley (H&NHC) 25801
200 Veterans Ave.
(304) 253-8383

Clarksburg (H) 26301
(304) 923-3411

Counties of Brooke, Hancock, Marshall and Ohio:
Pittsburgh, PA (RO) 15222
1000 Liberty Ave.
If you live in the local telephone area of:
Wheeling — 232-1431
Other: (800) 642-3520
(Huntington, WV RO)

Remaining counties in West Virginia served by:
Huntington, (RO) 25701
640 Fourth Avenue
If you live in the local telephone area of:
Charleston — 344-3531
Huntington — 529-5720
All other areas in West Virginia — (800) 642-3520

Huntington (H) 25704
1540 Spring Valley Dr.
(304) 429-1381

Martinsburg (H&D) 25401
(304) 263-0266

Wheeling (OCS) 26003
11th & Chapline Sts.
(304) 234-0123

WISCONSIN

Madison (H) 53705
2500 Overlook Terrace
(608) 256-1901

Milwaukee (RO) 53202
342 N. Water St.
If you live in the local telephone area of:
Green Bay — 437-9001
Madison — 257-5467
Milwaukee — 278-8680
Racine — 637-6743
All other Wisconsin areas — (800) 242-9025

Tomah (H&NHC) 54660
(608) 372-3971

Wood (H,D&NHC) 53193
5000 W. National Ave.
(414) 384-2000

WYOMING

Cheyenne (RO) 82001
2360 E. Pershing Blvd.
If you live in the local telephone areas of:
Cheyenne — 778-7550
All other Wyoming areas — (800) 442-2761

Cheyenne (H&NHC) 82001
2360 E. Pershing Blvd.
(307) 778-7550

Sheridan (H) 82801
(307) 672-3473

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